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Subject: Message from TOLL FREE CALL (8774812708)

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 14, 2022 4:05 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: NYT piece

Agree with Steve except to say that it's just as bad as I expected it to be given previews of what they planned to say about bone data - glad I was excluded from this biased paper - many inaccurate statements and omissions regarding bone data interpretation and context, also interesting that they "commissioned" their own researchers to conclude what they were hoping and excluded my input because it did not fit their narrative.

I'd suggest writing a response but honestly not sure I (or we) want that kind of publicity.

Best,
~[redacted]

[redacted], MD, MPH, MAS
Assistant Professor of Pediatrics and of Medicine
Divisions of Pediatric Endocrinology and Endocrinology & Metabolism
Assistant Medical Director, Child and Adolescent Gender Center
University of California, San Francisco

Mission Hall
550 16th St, 4th Floor, Box 0434
San Francisco, CA 94143
E-mail: [redacted]@ucsf.edu
She/Her/Hers

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, November 14, 2022 3:37 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: NYT piece

Hi [redacted]

Happy to chat by phone. There were a number of misleading and incorrect statements, but overall, it wasn't as bad as I feared it might be.

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Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
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Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 14, 2022 8:28 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: NYT piece

Hi folks,
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https://www.nytimes.com/2022/11/14/health/puberty-blockers-transgender.html

I am very interested to hear your thoughts, if you care to share. Feel free to call if easier (in fact this may be most prudent). Currently wrangling the child to school, but available starting at 9.
Best, [redacted]

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

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Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

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From: [redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 7:30 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: SFDPH-CAGC grant

Thanks for clarifying, Steve.

Hope all is well with you.
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, November 14, 2022 3:06 PM
To: [redacted]@ucsf.edu>
Subject: Re: SFDPH-CAGC grant

Hi [redacted],

Unfortunately, given the specialization of this work, the SFDPH didn't think it would be possible to identify and hire new people for a project that ends in June—definitely a disappointment that our two key personnel on this project had. to leave prematurely.

Steve

Stephen M. Rosenthal, M.D.
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Monday, November 14, 2022 11:11 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: SFDPH-CAGC grant

Hi Steve,

This is unfortunate to hear. Is it possible to directly hire the interested person at UCSF from the subcontract organization?

Hate to see we are returning funds when you still have work to carry out on the project.

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 10, 2022 3:47 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Fw: SFDPH-CAGC grant

Hi [redacted] and [redacted],

As you know, we've had a significant and fruitful collaboration between the CAGC and SF-DPH for the last almost 6 years. This collaboration was in the form of an annual grant of approximately $325,000 to the CAGC to support our Community Outreach program for gender-diverse youth in San Francisco. In the past year, this funding was primarily for salary support of 2 members of our CAGC team: [redacted], LPCC, Director of Community-based Clinical Programs (I believe at 60% effort) and [redacted], who served as Director of Community based Clinical Services and Training (I believe at 30% effort). In addition, Dr. [redacted] and I each served as Supervisors on this grant and received support in the range of

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5-7 %.

Unexpectedly, [redacted] informed us that he had accepted a new full-time job outside of UCSF as of early October, and [redacted] very recently informed us that because of [redacted], they will be leaving UCSF as of the end of this month. Unfortunately, we do not have other personnel who could step in and take over the work of [redacted] and [redacted] for the DPH grant. I explored with the DPH whether or not it would be possible for us to identify new people through a subcontract that could continue this work through the end of the current academic year's funding period of June 30, 2023. As you will see from the email below, this will not be possible.

What this means is that the current grant, which runs through June 30, 2023, now will end on November 30, 2022. UCSF will have 45 days to submit final invoices.

It's sad to not be able to continue this work that was already funded for another 7 months, but I don't see any other options.

Please let me know if you have any questions.

Thanks,

Steve

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email: Stephen.Rosenthal@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 10, 2022 3:20 PM
To: [redacted] (DPH) <[redacted]@sfdph.org>
Cc: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: SFDPH-CAGC grant

Hi [redacted],

Thanks for your clear response, which is very understandable. I will inform our Business Manager from Pediatric Endocrinology so that the final invoices can be submitted in a timely manner.

Please know how grateful I and our team have been for this nearly 6-year collaboration. I truly appreciate your and [redacted]s incredible support and belief in our mission and also hope there will be new opportunities for collaboration in the near future.

Sincerely,

Steve

Stephen M. Rosenthal, M.D.
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Tel.: (415) 476-2266
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email: Stephen.Rosenthal@ucsf.edu

From: [redacted] (DPH) <[redacted]@sfdph.org>
Sent: Thursday, November 10, 2022 2:52 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: RE: SFDPH-CAGC grant

This Message Is From an External Sender
This message came from outside your organization.

Hi Steve,

It was great to meet with you and J on Monday. I had the opportunity to consult with [redacted] today to propose using some of the remaining contractual funds for capacity-building activities through subcontract. In the long run, additional processes with budget modifications and other contractual revisions could complicate the target of winding down CAGC direct services at the end of this month. For example, we would have to do a whole contract revision to add any subcontractor to your budget which could take some time. After considering these additional processes and the remaining contract term, it boiled down to ensuring a smooth and clean end to the contract. I wish there were an easy way, but our efforts would not be as fruitful given these contractual processes.

Regarding invoicing, a provider typically has 45 days to submit their last invoice. [redacted] noted that UC's finance team should have the invoices to complete submission by the end of this year.

I want to express my immense gratitude to you and the CAGC teams for being in the forefront of gender-affirming clinical practice and care for trans and gender-diverse kids and families. CAGC saves so many young lives from experiencing undue distress and suffering for just being who they are. Thank you for allowing me to your team's work. I am immensely proud of CAGC 's positive impact on our system of care and clients. I look forward to continued collaborations and support in the near future.

Sincerely,

[redacted]

[redacted], MPH
Director
Gender Health SF
SFDPH, Castro Mission Health Center
3850 17th Street, San Francisco, CA 94114
Tel: ([redacted]) [redacted] Fax: ([redacted]) [redacted]
[redacted]@sfdph.org
Pronouns: she/her

CONFIDENTIALITY NOTICE: This email is intended for the recipient only. If Protected Health Information (PHI) is contained in this email, unauthorized disclosure may subject the discloser to civil or criminal penalties under state and federal privacy laws. If you received this email in error, notify me and destroy the email immediately.

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 9, 2022 12:19 PM
To: [redacted] (DPH) <[redacted]@sfdph.org>
Cc: [redacted] (UCSF) <[redacted]@ucsf.edu>; [redacted] (UCSF) <[redacted]@ucsf.edu>
Subject: SFDPH-CAGC grant

This message is from outside the City email system. Do not open links or attachments from untrusted sources.

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Hi [redacted],

It was great to meet by zoom with you and [redacted] on Monday. I wanted to follow-up with you regarding the possibility of continuing the grant in a limited form through the end of the current funding period (June, 2023) by continuing to do the capacity building work. I have initiated a conversation with [redacted] and Dr. [redacted] to determine who we might identify that could do this work on a contract basis through Pediatric Endocrinology at UCSF.

You mentioned that you would be checking in with [redacted] about this possibility. Please let us know as soon as you can if this is of interest, and we will work to figure things out on our end, as Community Outreach continues to be a high priority for the CAGC.

Thanks and best wishes,

Steve

Stephen M. Rosenthal, M.D.
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Division of Pediatric Endocrinology

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 9:42 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: NYT piece

Thanks so much for this, [redacted] and Steve. I agree that, while aggravating about the inaccuracies, it may not be worth responding to them about this. When your research is published, we'll do a big push to get it out into the world, including with these journalists, and that will more than speak for itself. But do let me know if you have different or further thoughts on this as time passes.
Thanks, [redacted]

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, November 14, 2022 4:17 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: NYT piece

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Cell/Text: [redacted]

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 15, 2022 10:15 AM PST
To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>
Subject: Re: XT paper

Many disappointing/frustrating inaccuracies re bone and more, including fertility. Prefer to discuss in real-time conversation.

[redacted]

Thanks,

Steve

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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 10:08 AM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: XT paper

Hi guys:

So saw the NYT article from yesterday that finally dropped - will be curious to hear your thoughts.

Among other things, I'm dismayed by how the skeletal health discussion read. A lot of careless language mixing up BMD and BMD z-scores and assigning causality to blockers for very low BMD z-scores without a baseline - they indirectly acknowledged this, but it's disappointing [redacted]s TransYouth baseline data weren't cited there.

[redacted]

[redacted]

[redacted]

[redacted]

--
[redacted]
Department of Radiology and Biomedical Imaging

University of California, San Francisco
185 Berry Street, Suite 350
San Francisco, CA 94143
tel: 415.514.9658

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[redacted]@ucsf.edu

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 12:11 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
CC: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: RE: SFDPH-CAGC grant

Hi Steve,

I'm moving [redacted] to BCC. I'm so sorry to hear about this news but thank you for giving us this information, really appreciate that. Thank you for your fruitful collaboration and work on this grant.

[redacted] will need to work on the invoicing. Let us know if you have any questions or concerns in the meantime.

Best,

[redacted]

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Sent: Thursday, November 10, 2022 3:47 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
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San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 10, 2022 3:20 PM
To: [redacted] (DPH) <[redacted]@sfdph.org>
Cc: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: SFDPH-CAGC grant

Hi [redacted],

Thanks for your clear response, which is very understandable. I will inform our Business Manager from Pediatric Endocrinology so that the final invoices can be submitted in a timely manner.

Please know how grateful I and our team have been for this nearly 6-year collaboration. I truly appreciate your and [redacted]s incredible support and belief in our mission and also hope there will be new opportunities for collaboration in the near future.

Sincerely,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] (DPH) <[redacted]@sfdph.org>
Sent: Thursday, November 10, 2022 2:52 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: RE: SFDPH-CAGC grant

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This message came from outside your organization.

Hi Steve,

It was great to meet with you and [redacted] on Monday. I had the opportunity to consult with [redacted] today to propose using some of the remaining contractual funds for capacity-building activities through subcontract. In the long run, additional processes with budget modifications and other contractual revisions could complicate the target of winding down CAGC direct services at the end of this month. For example, we would have to do a whole contract revision to add any subcontractor to your budget which could take some time. After considering these additional processes and the remaining contract term, it boiled down to ensuring a smooth and clean end to the contract. I wish there were an easy way, but our efforts would not be as fruitful given these contractual processes.

Regarding invoicing, a provider typically has 45 days to submit their last invoice. [redacted] noted that UC's finance team should have the invoices to complete submission by the end of this year.

I want to express my immense gratitude to you and the CAGC teams for being in the forefront of gender-affirming clinical practice and care for trans and gender-diverse kids and families. CAGC saves so many young lives from experiencing undue distress and

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suffering for just being who they are. Thank you for allowing me to your team's work. I am immensely proud of CAGC 's positive impact on our system of care and clients. I look forward to continued collaborations and support in the near future.

Sincerely,

[redacted]

[redacted], MPH
Director
Gender Health SF
SFDPH, Castro Mission Health Center
3850 17th Street, San Francisco, CA 94114
Tel: ([redacted]) [redacted] Fax: ([redacted]) [redacted]
[redacted]@sfdph.org
Pronouns: she/her

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 9, 2022 12:19 PM
To: [redacted] (DPH) <[redacted]@sfdph.org>
Cc: [redacted] (UCSF) <[redacted]@ucsf.edu>; [redacted] (UCSF) <[redacted]@ucsf.edu>
Subject: SFDPH-CAGC grant

This message is from outside the City email system. Do not open links or attachments from untrusted sources.

Hi [redacted],

It was great to meet by zoom with you and [redacted] on Monday. I wanted to follow-up with you regarding the possibility of continuing the grant in a limited form through the end of the current funding period (June, 2023) by continuing to do the capacity building work. I have initiated a conversation with [redacted] and Dr. [redacted] to determine who we might identify that could do this work on a contract basis through Pediatric Endocrinology at UCSF.

You mentioned that you would be checking in with [redacted] about this possibility. Please let us know as soon as you can if this is of interest, and we will work to figure things out on our end, as Community Outreach continues to be a high priority for the CAGC.

Thanks and best wishes,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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From: [redacted], [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 1:50 PM PST
To: [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
CC: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: Major backlog for CAGC new patient referrals

Hi [redacted],

We are in the process of confirming the funds flo through the FPO, which is the last step before an offer letter will go out. I have also sent a note to [redacted] about this so that he knows we are still intending to move forward with him.
I am so sorry for how long this has taken.

Thank you,

[redacted], LMFT
Service Line Director Behavioral Health
[redacted]@ucsf.edu
C: [redacted]

Administrative Assistant
[redacted]
[redacted]@ucsf.edu

UCSF Benioff Children's Hospitals

From: [redacted], [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, November 9, 2022 12:29 PM
To: [redacted], [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: FW: Major backlog for CAGC new patient referrals

Dear [redacted] and [redacted]:

I hope that you are well!
I am writing on behalf of our child and adolescent gender team with concern about the long delay in completing the hiring process for our preferred psychologist applicant. Would it be possible to please provide a status update – we are worried we may lose that candidate given the duration of the hiring process. Given the current dire situation of high need for mental health support for our patients, we are hoping to hear an update soon

Kind regards,
[redacted]

[redacted], MD, MHSc
Pronouns: she/her/hers
Selna L. Kaplan Chair Distinguished Professorship in Pediatric Endocrinology/Diabetes
Professor of Pediatrics
Chief, Division of Pediatric Endocrinology and Diabetes
University of California, San Francisco
Department of Pediatrics
Division of Pediatric Endocrinology
Mission Hall
550 16th St., 4th Floor, Box 0434
San Francisco, CA 94143
Tel: (415) 476-3310
Fax: (415) 476-5356
For FedEx deliveries, please use 94158
--

From: [redacted], Jason <[redacted]@ucsf.edu>
Date: Friday, November 4, 2022 at 5:07 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>, [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>, [redacted], [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>, [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>, [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>, [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>, [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Subject: RE: Major backlog for CAGC new patient referrals

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Steve,

Adding [redacted] who I'm hoping can provide an update related to the CAGC psychologist hire.

Thanks,

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, November 04, 2022 5:03 PM
To: [redacted]
Cc: [redacted]
Subject: Re: Major backlog for CAGC new patient referrals

Hi [redacted],

It's my understanding that capacity is currently maxed out for medical providers in the CAGC (including Adolescent Medicine, but I'll defer to [redacted], cc'd here, who can speak for himself as well as the other 2 Adolescent Med providers--[redacted] and [redacted]).

Rather than set up a zoom meeting now, I think the best solution, now that I see from [redacted] that the new CAGC APP has been approved, would be to get that position posted and filled as soon as possible. If that person's primary clinical focus is seeing new CAGC patients, that will make a major difference.

However, of course, the limiting capacity will then be mental health support—which we require for all new CAGC patients. The recent addition of two Child and Adolescent Psychiatrists has certainly helped, but we have yet to have the new CAGC psychologist position filled (vacant now for 13 months!). I believe you are aware of the long delays in completing the hiring process for our preferred psychologist applicant. We were told that person would be on-boarded in November, but we have gotten no response to our requests for a status update from Behavioral Health, and I fear we may lose that candidate. It might be helpful if you are able to intervene.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]
Sent: Friday, November 4, 2022 4:44 PM
To: [redacted] Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted]
Subject: Re: Major backlog for CAGC new patient referrals

Hi Steve- I agree we have reached a point where the need far outpaces the access to care for gender diverse youth – hiring the new PNP, bring [redacted] on faculty in Sept, and sending an offer to [redacted] are part of the plan – in the interim [redacted] has switched to seeing more gender patients than general endo – and we have some new adolescent med folks who could perhaps ramp up their

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clinic time in the interim? Im not sure what else we can do with the faculty we currently have… i.e. who has the capacity to see more patients than they already are… happy to have a call to discuss- I'll ask [redacted] to set one up – who would you like to be on ?

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Date: Friday, November 4, 2022 at 4:38 PM
To: [redacted] <[redacted]@ucsf.edu>, Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>
Subject: RE: Major backlog for CAGC new patient referrals

All,

The CAGC APP received FPO approval and is awaiting approval by the Labor Management Review committee before being pushed through to HR for posting. I will update the group as soon as it's posted, hopefully within the next week.

Thanks,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, November 04, 2022 4:35 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Major backlog for CAGC new patient referrals

Hi Steve,

Thank you for advocating for these patients! I included [redacted] in case he has additional updates on the new CAGC PNP hire. We continue to have patient demand for additional mental health and medical staffing. We should also be receiving additional nursing FTE when we add medical providers.

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Date: Friday, November 4, 2022 at 5:27 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>
Subject: Major backlog for CAGC new patient referrals

Hi [redacted],

I just had a meeting with clinic schedulers for the CAGC, including [redacted] from the Call Center (for Internal Referrals) and [redacted] from the Access Center (for External Referrals). I was shocked to learn that there are currently approximately 150 patients awaiting new CAGC appointments from the Access Center and an additional 80 patients awaiting new CAGC appointments from the Call Center = **230 patients currently waiting for a new patient CAGC appointment (!!!)** Some of our CAGC medical providers will be opening their CAGC templates for 2023, but this will only put a minor dent in addressing the need.

Can we set up a zoom to strategize?

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 3:15 PM PST
To: [redacted] <[redacted]@ucsf.edu>
CC: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Hi [redacted],

Can you confirm the work location? HR is asking.

Best,

[redacted]

From: [redacted]
Sent: Monday, November 7, 2022 3:43 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Will do-I'll submit the request today. Thank you [redacted]

Best,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 7, 2022 3:41 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Yes, you can include me as the resume receiver and reviewer.

Thanks so much,
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Date: Monday, November 7, 2022 at 3:38 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Hi [redacted],

[redacted]approved the essential hire request on Monday, 10/31. Can I include you as the resume receiver and reviewer? If so, someone from Talent Acquisition will contact you and walk you through the brassring system and getting access to the recruitment request so you can manage it internally. Once I have this info I can submit the JD to HR so they can review it and provide their approval.

Best,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 7, 2022 11:08 AM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Thank you for all your work to get my CSW position sorted out! I'm wanting to circle back to this CRC position now; do you know where things are at with this?

Best,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Date: Monday, October 17, 2022 at 3:56 PM

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To: [redacted] <[redacted]@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>
Subject: Re: New CRC position

Confirmed!
Thanks,
Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

San Francisco CA 94143-0434
Pronouns: he/him/his

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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, October 17, 2022 12:28 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Yes, you can review and organize the recruitment in BrassRing based on your position. I'll wait for Steve to confirm as well.

Best,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, October 17, 2022 12:26 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Thanks for keeping this ball rolling. Steve and I are planning to review the applicants together, if I'm allowed to based on my current position? I'll let Steve weigh in if there's anybody else he'd like to include in this, but not to my knowledge.

Thanks again,
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Date: Monday, October 17, 2022 at 12:13 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Hi [redacted],

I submitted the essential hire approval request. Once it's approved, I'll submit the new hire request to HR along with the JD. On the JD, I need to include who will receive and review the resumes in BrassRing, let me know if you would like for me to include someone else from Steve's team.

Best,

[redacted]

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, October 13, 2022 4:09 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

I provided the information you requested to the best of my ability, below in red. I've also attached the Word doc, which I think I filled out correctly. Please let us know if more information is needed or any revisions need to be made.

Thanks!
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Date: Wednesday, October 12, 2022 at 12:05 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: RE: New CRC position

Hi Steve,

For new staff recruitments, we will need to submit an essential hire request to the department to approve. The information I need for that is included below. I'll also need you to complete the attached Job Description (JD). You'll also want to make sure you have enough funding to support this position. Please provide me with the funding source you would like to use?

Once you complete the JD and the essential hire request information, I'll submit it to the department for approval. After the department approves, I will then submit new hire requests to HR. They will then post the positions in BrassRing and you will manage the search process.

Info needed for essential hire request.

- Are these new or replacement positions
  Splitting already existing position
- Type
  - Full Time
  - Part Time
  - Contract
  - Limited
- Job Code 9335
- Job title Clinical Research Coordinator
- Briefly describe the position's responsibilities
  The CRC will execute, manage, and coordinate research protocols, as directed by the Clinical Research Supervisor and/or Principal Investigator (PI) for the Trans Youth Care Study. Duties may include, but will not be limited to: understanding the regulatory, institutional, sponsor and protocol requirements for the study; recruiting and screening potential participants; conducting all aspects of the informed consent process with potential participants; scheduling and managing study participant study visits; collecting data from participants' medical records and entering it into study database.
- %FTE for the position
  40%
- Supervisor name
  Stephen M. Rosenthal, MD
- Funding Source for Position*
  - *Only positions with 100% confirmed funding will be approved. Please list the confirmed funding sources - include percent effort, Fund-DeptID-Project and if applicable, start & end dates.*

  NIH Grant, award number A138395, Trans Youth Care study. 40% FTE through 1/31/2026

Let me know if you have any questions.

Best,

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, October 10, 2022 5:56 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: New CRC position

Hi [redacted],

We would like to initiate a job search for a new part-time CRC position at 40% effort. This will be someone that [redacted], cc'd

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here, and I will both supervise. Please let us know how to proceed. We will be happy to complete the job description portions.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

San Francisco CA 94143-0434
Pronouns: he/him/his

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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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Subject: Magnet Moment announcement
Location: In person Locations below. Zoom link: https://ucsf.zoom.us/j/[redacted]

Start: Wednesday, November 16, 2022 12:30 PM PST
End: Wednesday, November 16, 2022 12:55 PM PST
Show Time As: Tentative

Recurrence: None

Meeting Status: Not yet responded

Organizer: [redacted]
Required Attendees: [redacted]@ucsf.edu>; UCSFMC-ALL-RNS@listsrv.ucsf.edu <UCSFMC-ALL-RNS@listsrv.ucsf.edu>; UCSF MDs <UCSFMDs@ucsf.edu>; UCSF Nursing-Nursing Leadership-Peds <UCSFNursing-NursingLeadership-Peds@ucsf.edu>; UCSF Nursing-Nursing Leadership-Adults <UCSFNursing-NursingLeadership-Adults@ucsf.edu>; Center for Nursing Excellence and Innovation <NursingExcellence@ucsf.edu>; Internal Communications <Internal.Communications@ucsf.edu>; Ambulatory Nurse Managers <AmbulatoryNurseManagers@ucsf.edu>; Ambulatory Practice Managers <AmbulatoryPracticeMgrs@ucsfmedctr.org>; Senior Leadership Council <SeniorLeadershipCouncil@ucsfmedctr.org>; System Executive Team <SystemExecutiveTeam@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; Nurse-All <Nurse-All@ucsf.edu>; [redacted]
J[redacted]@ucsf.edu>; Clinical Ops Leadership <ClinicalOpsLeadership@ucsf.edu>
Optional Attendees: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>;
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [

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[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [

Obtained via CPRA by Judicial Watch, Inc.

[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [

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[redacted]
Webinar ID: [redacted]
Passcode: [redacted]
International numbers available: [redacted]

[redacted]
Meeting ID: [redacted]
Passcode: [redacted]
SIP: [redacted]
Passcode: [redacted]

We are very excited to have you share this important event with us, and we look forward to your participation on Wednesday!

Sincerely,
[redacted] **DNP, MSN, RN, NEA-BC (he,him,his)**
System Chief Nurse Executive – UCSF Health
Strengths: Woo, Positivity, Relator, Input, Achiever, Futuristic

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 5:42 PM PST
To: [redacted] <[redacted]@ucsf.edu>
CC: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Is it possible to classify this as a fully remote position? If not, how specific of a location do you need?

Steve, can you confirm what location this position would be at? Do we have an address in the Pritzker building yet?

Thanks,
[redacted]

[redacted], ASW
(Pronouns: they/them/theirs)
Clinical Research Coordinator
UCSF Child & Adolescent Gender Center
(707) 722-0478 | [redacted]@ucsf.edu

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[redacted], MSW
(Pronouns: they/them/theirs)
Clinical Research Coordinator
Division of Pediatric Endocrinology
University of California, San Francisco
550 16th St., San Francisco CA 94143
(707) 722-0478 | [redacted]@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 3:15:36 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Hi [redacted],

Can you confirm the work location? HR is asking.

Best,

[redacted]

From: [redacted]
Sent: Monday, November 7, 2022 3:43 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Will do-I'll submit the request today. Thank you [redacted]

Best,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 7, 2022 3:41 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

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Obtained via CPRA by Judicial Watch, Inc.

Yes, you can include me as the resume receiver and reviewer.

Thanks so much,
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Date: Monday, November 7, 2022 at 3:38 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Hi [redacted],

[redacted] approved the essential hire request on Monday, 10/31. Can I include you as the resume receiver and reviewer? If so, someone from Talent Acquisition will contact you and walk you through the brassring system and getting access to the recruitment request so you can manage it internally. Once I have this info I can submit the JD to HR so they can review it and provide their approval.

Best,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 7, 2022 11:08 AM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Thank you for all your work to get my CSW position sorted out! I'm wanting to circle back to this CRC position now; do you know where things are at with this?

Best,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Date: Monday, October 17, 2022 at 3:56 PM
To: [redacted] <[redacted]@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>
Subject: Re: New CRC position

Confirmed!
Thanks,
Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, October 17, 2022 12:28 PM
To: [redacted] <[redacted]@ucsf.edu>

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Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Yes, you can review and organize the recruitment in BrassRing based on your position. I'll wait for Steve to confirm as well.

Best,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, October 17, 2022 12:26 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Thanks for keeping this ball rolling. Steve and I are planning to review the applicants together, if I'm allowed to based on my current position? I'll let Steve weigh in if there's anybody else he'd like to include in this, but not to my knowledge.

Thanks again,
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Date: Monday, October 17, 2022 at 12:13 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Hi [redacted],

I submitted the essential hire approval request. Once it's approved, I'll submit the new hire request to HR along with the JD. On the JD, I need to include who will receive and review the resumes in BrassRing, let me know if you would like for me to include someone else from Steve's team.

Best,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, October 13, 2022 4:09 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

I provided the information you requested to the best of my ability, below in red. I've also attached the Word doc, which I think I filled out correctly. Please let us know if more information is needed or any revisions need to be made.

Thanks!
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Date: Wednesday, October 12, 2022 at 12:05 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: RE: New CRC position

Hi Steve,

For new staff recruitments, we will need to submit an essential hire request to the department to approve. The information I need for that is included below. I'll also need you to complete the attached Job Description (JD). You'll also want to make sure you have enough funding to support this position. Please provide me with the funding source you would like to use?

Once you complete the JD and the essential hire request information, I'll submit it to the department for approval. After the department approves, I will then submit new hire requests to HR. They will then post the positions in BrassRing and you will manage the search process.

Info needed for essential hire request.

- Are these new or replacement positions

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Splitting already existing position

- Type
  - Full Time
  - Part Time
  - Contract
  - Limited
- Job Code 9335
- Job title Clinical Research Coordinator
- Briefly describe the position's responsibilities
  The CRC will execute, manage, and coordinate research protocols, as directed by the Clinical Research Supervisor and/or Principal Investigator (PI) for the Trans Youth Care Study. Duties may include, but will not be limited to: understanding the regulatory, institutional, sponsor and protocol requirements for the study; recruiting and screening potential participants; conducting all aspects of the informed consent process with potential participants; scheduling and managing study participant study visits; collecting data from participants' medical records and entering it into study database.
- %FTE for the position
  40%
- Supervisor name
  Stephen M. Rosenthal, MD
- Funding Source for Position*
  - *Only positions with 100% confirmed funding will be approved. Please list the confirmed funding sources - include percent effort, Fund-DeptID-Project and if applicable, start & end dates.*

  NIH Grant, award number A138395, Trans Youth Care study. 40% FTE through 1/31/2026

Let me know if you have any questions.

Best,

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, October 10, 2022 5:56 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: New CRC position

Hi [redacted],

We would like to initiate a job search for a new part-time CRC position at 40% effort. This will be someone that [redacted], cc'd here, and I will both supervise. Please let us know how to proceed. We will be happy to complete the job description portions.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

San Francisco CA 94143-0434
Pronouns: he/him/his

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Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 15, 2022 5:46 PM PST
To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>
Subject: Re: XT paper

[redacted]

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
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Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 2:47 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: XT paper

Frustrating

[redacted]

[redacted]

—
[redacted]
Department of Radiology and Biomedical Imaging

University of California, San Francisco
185 Berry Street, Suite 350
San Francisco, CA 94143
tel: 415.514.9658
[redacted]@ucsf.edu

On Nov 15, 2022, at 10:15 AM, [redacted] [redacted]@ucsf.edu> wrote:

Hi [redacted]

Steve's aware of all the back and forth e-mailing and clarifications I sent to the NYT reporters. They ultimately dropped me from the story (thankfully) because my perspectives obviously did not fit the narrative they were aiming for from the start.

I pointed out to them that they were conflating density with strength (which I explicitly told them was incorrect), and also pointed out a lot of the inaccuracies that they still kept in their story. Even more flabbergasting is that they "commissioned" their own data analyses in order to bolster their messaging. I made exactly the point that we need to be focused on this subgroup of TGD youth who have low baseline BMD. It's all on record via e-mail since I insisted we communicate in written format rather than over the phone.

[redacted]

Best,
~[redacted]

[redacted] MD, MPH, MAS
Assistant Professor of Pediatrics and of Medicine
Divisions of Pediatric Endocrinology and Endocrinology & Metabolism
Assistant Medical Director, Child and Adolescent Gender Center
University of California, San Francisco

Mission Hall
550 16th St, 4th Floor, Box 0434
San Francisco, CA 94143
E-mail: [redacted]@ucsf.edu
She/Her/Hers

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 10:08 AM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: XT paper

Hi guys:

So saw the NYT article from yesterday that finally dropped - will be curious to hear your thoughts.

Among other things, I'm dismayed by how the skeletal health discussion read. A lot of careless language mixing up BMD and BMD z-scores and assigning causality to blockers for very low BMD z-scores without a baseline - they indirectly acknowledged this, but it's disappointing [redacted]s TransYouth baseline data weren't cited there.

[redacted]

[redacted]

[redacted]

[redacted]

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[redacted]
Department of Radiology and Biomedical Imaging

University of California, San Francisco
185 Berry Street, Suite 350
San Francisco, CA 94143
tel: 415.514.9658
[redacted]@ucsf.edu

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	Fiscal Year: 2022-2023			
Number	DATE	Oraganization/Contact Person	# of Attendees	Training Topic
1	July 18th 2022	OTTP SF [redacted]@ottp-sf.org [redacted]clinical supervisor [redacted]	18	Gender-well: clinical support for TGD youth
2	July 26th 2022	Zuckerberg San Francisco General Hospital Pediatric Department [redacted]	32	Interdisciplinary Approach to Gender Affirmative Care
3	August 24th 2022	UCSF Obstectrics/Gynecology and Reproductive Services Health Equity Research Group [redacted]	36	Health Disparities Among Gender Diverse Youth
4	September 3rd, 2022	[redacted] and [redacted] Open to providers through Mind the Gap	52	Gender Health Assessment/Evaluations from a Family Model
5	September 8th, 2022	UCSF Clinical Leadership Council, presenter [redacted], Medical Treatment for Transgender/Gender Diverse Youth.	30	Medical Treatment for Transgender/Gender Diverse Youth.
6	September 14th, 2022	The Lotus Collaborative, intro webinar training to prep for synchronous training	25	Overview of Gender-Affirmative Clinical Care, webinar
7	September 21st, 2022	The Lotus Collaborative	20	Supporting TGD clients with navigating eating disorders and body image
8	October 2nd, 2022	[redacted]open training/discussion	40	Open Training via Mind the Gap: Overview of WPATH SOC 8, Adolescent Chapter
9	November 2nd, 2022	Gender Affirmative Care with Children, Youth and Young Adults , SFDPH, Zuckerberg Child Psych, [redacted]	17	
		total 270 providers served FY 22-23 (June 2022 to November 2022)		

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 15, 2022 5:49 PM PST
To: [redacted], [redacted] <[redacted]@ucsf.edu>
Subject: Re: One more (for now) :)

Thanks, [redacted]!

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
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Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted], [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 14, 2022 5:52 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: One more (for now) :)

Hi Steve,

Here you go!

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, November 14, 2022 5:16 PM
To: [redacted], [redacted] <[redacted]@ucsf.edu>
Subject: One more (for now) :)

Hi [redacted],

Please put the attached letter on letterhead and send back to me as both a Word document and PDF. I have to submit the letter by 11/17. You'll see I had trouble with the spacing of paragraphs and with my signature block in the letter.

Thanks very much,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
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	Fiscal Year: 2022-2023			
Number	DATE	Oraganization/Contact Person	# of Attendees	Training Topic
1	July 18th 2022	OTTP SF [redacted]@ottp-sf.org [redacted] clinical supervisor [redacted]	18	Gender-well: clinical support for TGD youth
2	July 26th 2022	Zuckerberg San Francisco General Hospital Pediatric Department [redacted]	32	Interdisciplinary Approach to Gender Affirmative Care
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		total 270 providers served FY 22-23 (June 2022 to November 2022)		

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 15, 2022 5:56 PM PST
To: [redacted]@ucsf.edu>
Subject: Re: SFDPH-CAGC grant

You're welcome, [redacted]. I hope all is well with you and your family, too!

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
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Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 7:30 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: SFDPH-CAGC grant

Thanks for clarifying, Steve.

Hope all is well with you.
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, November 14, 2022 3:06 PM
To: [redacted]@ucsf.edu>
Subject: Re: SFDPH-CAGC grant

Hi [redacted],

Unfortunately, given the specialization of this work, the SFDPH didn't think it would be possible to identify and hire new people for a project that ends in June—definitely a disappointment that our two key personnel on this project had. to leave prematurely.

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
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Medical Director, Child and Adolescent Gender Center
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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Monday, November 14, 2022 11:11 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: SFDPH-CAGC grant

Hi Steve,

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This is unfortunate to hear. Is it possible to directly hire the interested person at UCSF from the subcontract organization?

Hate to see we are returning funds when you still have work to carry out on the project.

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 10, 2022 3:47 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Fw: SFDPH-CAGC grant

Hi [redacted] and [redacted],

As you know, we've had a significant and fruitful collaboration between the CAGC and SF-DPH for the last almost 6 years. This collaboration was in the form of an annual grant of approximately $325,000 to the CAGC to support our Community Outreach program for gender-diverse youth in San Francisco. In the past year, this funding was primarily for salary support of 2 members of our CAGC team: [redacted], LPCC, Director of Community-based Clinical Programs (I believe at 60% effort) and [redacted], who served as Director of Community based Clinical Services and Training (I believe at 30% effort). In addition, Dr. [redacted] and I each served as Supervisors on this grant and received support in the range of 5-7 %.

Unexpectedly, [redacted] informed us that he had accepted a new full-time job outside of UCSF as of early October, and [redacted] very recently informed us that because of [redacted], they will be leaving UCSF as of the end of this month. Unfortunately, we do not have other personnel who could step in and take over the work of [redacted] and [redacted] for the DPH grant. I explored with the DPH whether or not it would be possible for us to identify new people through a subcontract that could continue this work through the end of the current academic year's funding period of June 30, 2023. As you will see from the email below, this will not be possible.

What this means is that the current grant, which runs through June 30, 2023, now will end on November 30, 2022. UCSF will have 45 days to submit final invoices.

It's sad to not be able to continue this work that was already funded for another 7 months, but I don't see any other options.

Please let me know if you have any questions.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 10, 2022 3:20 PM
To: [redacted] (DPH) <[redacted]@sfdph.org>
Cc: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: SFDPH-CAGC grant

Hi [redacted],

Thanks for your clear response, which is very understandable. I will inform our Business Manager from Pediatric Endocrinology so that the final invoices can be submitted in a timely manner.

Please know how grateful I and our team have been for this nearly 6-year collaboration. I truly appreciate your and [redacted]s incredible support and belief in our mission and also hope there will be new opportunities for collaboration in the near future.

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Obtained via CPRA by Judicial Watch, Inc.

Sincerely,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] (DPH) <[redacted]@sfdph.org>
Sent: Thursday, November 10, 2022 2:52 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: RE: SFDPH-CAGC grant

This Message Is From an External Sender
This message came from outside your organization.

Hi Steve,

It was great to meet with you and [redacted] on Monday. I had the opportunity to consult with [redacted] today to propose using some of the remaining contractual funds for capacity-building activities through subcontract. In the long run, additional processes with budget modifications and other contractual revisions could complicate the target of winding down CAGC direct services at the end of this month. For example, we would have to do a whole contract revision to add any subcontractor to your budget which could take some time. After considering these additional processes and the remaining contract term, it boiled down to ensuring a smooth and clean end to the contract. I wish there were an easy way, but our efforts would not be as fruitful given these contractual processes.

Regarding invoicing, a provider typically has 45 days to submit their last invoice. [redacted] noted that UC's finance team should have the invoices to complete submission by the end of this year.

I want to express my immense gratitude to you and the CAGC teams for being in the forefront of gender-affirming clinical practice and care for trans and gender-diverse kids and families. CAGC saves so many young lives from experiencing undue distress and suffering for just being who they are. Thank you for allowing me to your team's work. I am immensely proud of CAGC 's positive impact on our system of care and clients. I look forward to continued collaborations and support in the near future.

Sincerely,

[redacted]

[redacted], MPH
Director
Gender Health SF
SFDPH, Castro Mission Health Center
3850 17th Street, San Francisco, CA 94114
Tel: ([redacted]) [redacted] Fax: ([redacted]) [redacted]
[redacted]@sfdph.org
Pronouns: she/her

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Obtained via CPRA by Judicial Watch, Inc.

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 9, 2022 12:19 PM
To: [redacted] (DPH) <[redacted]@sfdph.org>
Cc: [redacted] (UCSF) <[redacted]@ucsf.edu>; [redacted] (UCSF) <[redacted]@ucsf.edu>
Subject: SFDPH-CAGC grant

This message is from outside the City email system. Do not open links or attachments from untrusted sources.

Hi [redacted],

It was great to meet by zoom with you and [redacted] on Monday. I wanted to follow-up with you regarding the possibility of continuing the grant in a limited form through the end of the current funding period (June, 2023) by continuing to do the capacity building work. I have initiated a conversation with [redacted] and Dr. [redacted] to determine who we might identify that could do this work on a contract basis through Pediatric Endocrinology at UCSF.

You mentioned that you would be checking in with [redacted] about this possibility. Please let us know as soon as you can if this is of interest, and we will work to figure things out on our end, as Community Outreach continues to be a high priority for the CAGC.

Thanks and best wishes,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 15, 2022 5:57 PM PST
To: [redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: SFDPH-CAGC grant

Thanks, [redacted].

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 12:11 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: RE: SFDPH-CAGC grant

Hi Steve,

I'm moving [redacted] to BCC. I'm so sorry to hear about this news but thank you for giving us this information, really appreciate that. Thank you for your fruitful collaboration and work on this grant.

[redacted] will need to work on the invoicing. Let us know if you have any questions or concerns in the meantime.

Best,

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 10, 2022 3:47 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Fw: SFDPH-CAGC grant

Hi [redacted] and [redacted],

As you know, we've had a significant and fruitful collaboration between the CAGC and SF-DPH for the last almost 6 years. This collaboration was in the form of an annual grant of approximately $325,000 to the CAGC to support our Community Outreach program for gender-diverse youth in San Francisco. In the past year, this funding was primarily for salary support of 2 members of our CAGC team: [redacted], LPCC, Director of Community-based Clinical Programs (I believe at 60% effort) and [redacted], who served as Director of Community based Clinical Services and Training (I believe at 30% effort). In addition, Dr. [redacted] and I each served as Supervisors on this grant and received support in the range of 5-7 %.

Unexpectedly, [redacted] informed us that he had accepted a new full-time job outside of UCSF as of early October, and [redacted] very recently informed us that because of [redacted], they will be leaving UCSF as of the end of this month. Unfortunately, we do not have other personnel who could step in and take over the work of [redacted] and [redacted] for the DPH grant. I explored with the DPH whether or not it would be possible for us to identify new people through a subcontract that could continue this work through the end of the current academic year's funding period of June 30, 2023. As you will see from the email below, this will not be possible.

What this means is that the current grant, which runs through June 30, 2023, now will end on November 30, 2022. UCSF will have 45 days to submit final invoices.

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It's sad to not be able to continue this work that was already funded for another 7 months, but I don't see any other options.

Please let me know if you have any questions.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 10, 2022 3:20 PM
To: [redacted], [redacted] (DPH) <[redacted]@sfdph.org>
Cc: [redacted], [redacted] <[redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>
Subject: Re: SFDPH-CAGC grant

Hi [redacted],

Thanks for your clear response, which is very understandable. I will inform our Business Manager from Pediatric Endocrinology so that the final invoices can be submitted in a timely manner.

Please know how grateful I and our team have been for this nearly 6-year collaboration. I truly appreciate your and [redacted]'s incredible support and belief in our mission and also hope there will be new opportunities for collaboration in the near future.

Sincerely,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted], [redacted] (DPH) <[redacted]@sfdph.org>
Sent: Thursday, November 10, 2022 2:52 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted], [redacted] <[redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>
Subject: RE: SFDPH-CAGC grant

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Hi Steve,

It was great to meet with you and [redacted] on Monday. I had the opportunity to consult with [redacted] today to propose using some of the remaining contractual funds for capacity-building activities through subcontract. In the long run, additional processes with budget modifications and other contractual revisions could complicate the target of winding down CAGC direct services at the end of this month. For example, we would have to do a whole contract revision to add any subcontractor to your budget which could take some time. After considering these additional processes and the remaining contract term, it boiled down to ensuring a smooth and clean end to the contract. I wish there were an easy way, but our efforts would not be as fruitful given these contractual processes.

Regarding invoicing, a provider typically has 45 days to submit their last invoice. [redacted] noted that UC's finance team should have the invoices to complete submission by the end of this year.

I want to express my immense gratitude to you and the CAGC teams for being in the forefront of gender-affirming clinical practice and care for trans and gender-diverse kids and families. CAGC saves so many young lives from experiencing undue distress and suffering for just being who they are. Thank you for allowing me to your team's work. I am immensely proud of CAGC 's positive impact on our system of care and clients. I look forward to continued collaborations and support in the near future.

Sincerely,

[redacted]

[redacted], MPH
Director
Gender Health SF
SFDPH, Castro Mission Health Center
3850 17th Street, San Francisco, CA 94114
Tel: ([redacted]) [redacted] Fax: ([redacted]) [redacted]
[redacted]@sfdph.org
Pronouns: she/her

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 9, 2022 12:19 PM
To: [redacted] (DPH) <[redacted]@sfdph.org>
Cc: [redacted] (UCSF) <[redacted]@ucsf.edu>; [redacted] (UCSF) <[redacted]@ucsf.edu>
Subject: SFDPH-CAGC grant

This message is from outside the City email system. Do not open links or attachments from untrusted sources.

Hi [redacted],

It was great to meet by zoom with you and [redacted] on Monday. I wanted to follow-up with you regarding the possibility of continuing the grant in a limited form through the end of the current funding period (June, 2023) by continuing to do the capacity building work. I have initiated a conversation with [redacted] and Dr. [redacted] to determine who we might identify that could do this work on a contract basis through Pediatric Endocrinology at UCSF.

You mentioned that you would be checking in with [redacted] about this possibility. Please let us know as soon as you can if this is of interest, and we will work to figure things out on our end, as Community Outreach continues to be a high priority for the CAGC.

Thanks and best wishes,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
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email: Stephen.Rosenthal@ucsf.edu

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 15, 2022 6:02 PM PST
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

[redacted]

Thanks,
Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 5:42 PM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Is it possible to classify this as a fully remote position? If not, how specific of a location do you need?

Steve, can you confirm what location this position would be at? Do we have an address in the Pritzker building yet?

Thanks,
[redacted]
--

[redacted], ASW
(Pronouns: they/them/theirs)
Clinical Research Coordinator
UCSF Child & Adolescent Gender Center
(707) 722-0478 | [redacted]@ucsf.edu

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--

[redacted], MSW
(Pronouns: they/them/theirs)
Clinical Research Coordinator
Division of Pediatric Endocrinology
University of California, San Francisco
550 16th St., San Francisco CA 94143
(707) 722-0478 | [redacted]@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 3:15:36 PM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

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Hi [redacted],

Can you confirm the work location? HR is asking.

Best,

[redacted]

From: [redacted]
Sent: Monday, November 7, 2022 3:43 PM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Will do-I'll submit the request today. Thank you [redacted]!

Best,

[redacted]

From: [redacted]@ucsf.edu>
Sent: Monday, November 7, 2022 3:41 PM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Yes, you can include me as the resume receiver and reviewer.

Thanks so much,
[redacted]

From: [redacted]@ucsf.edu>
Date: Monday, November 7, 2022 at 3:38 PM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Hi [redacted],

[redacted] approved the essential hire request on Monday, 10/31. Can I include you as the resume receiver and reviewer? If so, someone from Talent Acquisition will contact you and walk you through the brassring system and getting access to the recruitment request so you can manage it internally. Once I have this info I can submit the JD to HR so they can review it and provide their approval.

Best,

[redacted]

From: [redacted]@ucsf.edu>
Sent: Monday, November 7, 2022 11:08 AM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Thank you for all your work to get my CSW position sorted out! I'm wanting to circle back to this CRC position now; do you know where things are at with this?

Best,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Date: Monday, October 17, 2022 at 3:56 PM
To: [redacted]@ucsf.edu>, [redacted]@ucsf.edu>
Subject: Re: New CRC position

Confirmed!
Thanks,

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Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
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Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, October 17, 2022 12:28 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Yes, you can review and organize the recruitment in BrassRing based on your position. I'll wait for Steve to confirm as well.

Best,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, October 17, 2022 12:26 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Thanks for keeping this ball rolling. Steve and I are planning to review the applicants together, if I'm allowed to based on my current position? I'll let Steve weigh in if there's anybody else he'd like to include in this, but not to my knowledge.

Thanks again,
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Date: Monday, October 17, 2022 at 12:13 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Hi [redacted],

I submitted the essential hire approval request. Once it's approved, I'll submit the new hire request to HR along with the JD. On the JD, I need to include who will receive and review the resumes in BrassRing, let me know if you would like for me to include someone else from Steve's team.

Best,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, October 13, 2022 4:09 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

I provided the information you requested to the best of my ability, below in red. I've also attached the Word doc, which I think I filled out correctly. Please let us know if more information is needed or any revisions need to be made.

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Thanks!
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Date: Wednesday, October 12, 2022 at 12:05 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: RE: New CRC position

Hi Steve,

For new staff recruitments, we will need to submit an essential hire request to the department to approve. The information I need for that is included below. I'll also need you to complete the attached Job Description (JD). You'll also want to make sure you have enough funding to support this position. Please provide me with the funding source you would like to use?

Once you complete the JD and the essential hire request information, I'll submit it to the department for approval. After the department approves, I will then submit new hire requests to HR. They will then post the positions in BrassRing and you will manage the search process.

Info needed for essential hire request.

- Are these new or replacement positions
  Splitting already existing position
- Type
  - Full Time
  - Part Time
  - Contract
  - Limited
- Job Code 9335
- Job title Clinical Research Coordinator
- Briefly describe the position's responsibilities
  The CRC will execute, manage, and coordinate research protocols, as directed by the Clinical Research Supervisor and/or Principal Investigator (PI) for the Trans Youth Care Study. Duties may include, but will not be limited to: understanding the regulatory, institutional, sponsor and protocol requirements for the study; recruiting and screening potential participants; conducting all aspects of the informed consent process with potential participants; scheduling and managing study participant study visits; collecting data from participants' medical records and entering it into study database.
- %FTE for the position
  40%
- Supervisor name
  Stephen M. Rosenthal, MD
- Funding Source for Position*
  - *Only positions with 100%confirmed funding will be approved. Please list the confirmed funding sources - include percent effort, Fund-DeptID-Project and if applicable, start & end dates.*

  NIH Grant, award number A138395, Trans Youth Care study. 40% FTE through 1/31/2026

Let me know if you have any questions.

Best,

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, October 10, 2022 5:56 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: New CRC position

Hi [redacted],

We would like to initiate a job search for a new part-time CRC position at 40% effort. This will be someone that [redacted], cc'd here, and I will both supervise. Please let us know how to proceed. We will be happy to complete the job description portions.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco

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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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From: Rosenthal, Stephen
Sent: Tuesday, November 15, 2022 6:25 PM PST
To: [redacted] <[redacted]@ucsf.edu>
CC: [redacted] <[redacted]@ucsf.edu>; [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Subject: Please cancel CAGC Staff mtg for 11/22 and Research team mtg for 11/22

Hi [redacted]

Please send out a note to the full CAGC team that we are canceling the CAGC team meeting for 11/22 from 5:15-6:15 PM.

Please also send out a note (so their calendars can be adjusted) to [redacted] and [redacted] (both cc'd here) that we won't be having our weekly team research mtg (11:35 AM-noon) on 11/22.

Thanks, and I hope you have a nice Thanksgiving!

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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From: [redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 8:37 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: XT paper

I know it's not saying much, but the NYT article was not as bad as I expected it would be. It is disappointing, but I was bracing for something worse.

The bone stuff was badly done. What's up with that supposed DXA report for the 15 y.o. in Texas? It makes it ironic that the final sentence argues for "less vitriol, more science".

[redacted]

Best,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 15, 2022 5:46 PM
To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: XT paper

[redacted]

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 2:47 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: XT paper

Frustrating

[redacted]

[redacted]

—
[redacted]
Department of Radiology and Biomedical Imaging

University of California, San Francisco
185 Berry Street, Suite 350
San Francisco, CA 94143
tel: 415.514.9658
[redacted]@ucsf.edu

> On Nov 15, 2022, at 10:15 AM, [redacted] [redacted]@ucsf.edu> wrote:
>
> Hi [redacted]
>
> Steve's aware of all the back and forth e-mailing and clarifications I sent to the NYT reporters. They ultimately dropped me from the story (thankfully) because my perspectives obviously did not fit the narrative they were aiming for from the start.
>
> I pointed out to them that they were conflating density with strength (which I explicitly told them was incorrect), and also pointed out a lot of the inaccuracies that they still kept in their story. Even more flabbergasting is that they "commissioned" their own data analyses in order to bolster their messaging. I made exactly the point that we need to be focused on this subgroup of TGD youth who have low baseline BMD. It's all on record via e-mail since I insisted we communicate in written format rather than over the phone.
>
> [redacted]
>
> Best,
> [redacted]
>
> [redacted] MD, MPH, MAS
> Assistant Professor of Pediatrics and of Medicine
> Divisions of Pediatric Endocrinology and Endocrinology & Metabolism
> Assistant Medical Director, Child and Adolescent Gender Center
> University of California, San Francisco
>
> Mission Hall
> 550 16th St, 4th Floor, Box 0434
> San Francisco, CA 94143
> E-mail: [redacted]@ucsf.edu
> *She/Her/Hers*
>
> **From:** [redacted]@ucsf.edu>

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Sent: Tuesday, November 15, 2022 10:08 AM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: XT paper

Hi guys:

So saw the NYT article from yesterday that finally dropped - will be curious to hear your thoughts.

Among other things, I'm dismayed by how the skeletal health discussion read. A lot of careless language mixing up BMD and BMD z-scores and assigning causality to blockers for very low BMD z-scores without a baseline - they indirectly acknowledged this, but it's disappointing [redacted]'s TransYouth baseline data weren't cited there.

[redacted]

[redacted]
Department of Radiology and Biomedical Imaging

University of California, San Francisco
185 Berry Street, Suite 350
San Francisco, CA 94143
tel: 415.514.9658
[redacted]@ucsf.edu

Obtained via CPRA by Judicial Watch, Inc.

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From: Rosenthal, Stephen
Sent: Wednesday, November 16, 2022 9:34 AM PST
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: SOC8 and Bone

Hi Maddie,

SOC8 does include specific content on bone health for kids. Specifically, SOC8 states that "Bone Mass" should be determined prior to starting Rx with GnRHa, and should be monitored during the course of GnRHa Rx. It also states there are no data to support use of GnRHa (as monotherapy) in someone older than 14 without posing a risk to bone health.

In terms of whether something was included as a formal recommendation vs. commented on in the text had to do with the Delphi process—e.g. a recommendation to not use GnRHa as a monotherapy after the age of 14 did not pass Delphi.

Here's what is the specific text related to Bone in SOC8:

When deciding on the duration of GnRHa monotherapy, all contributing factors should be considered, including factors such as pretreatment bone mass...

The **clinical course of the treatment**, e.g., the **development of bone mass during GnRHa treatment** and the adolescent's response to treatment, **can help to determine the length of GnRHa monotherapy.**

In addition, for **adolescents older than 14 years**, there are currently **no data** to inform HCPs **whether GnRHas can be administered as mono- therapy (and for what duration) without posing a significant risk to skeletal health.**

Also, it should be noted that the current version of the Endocrine Society CPG, co-sponsored by WPATH, also noted that bone studies should be obtained before starting GnRHa, and then every 1-2 yr.

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

Obtained via CPRA by Judicial Watch, Inc.

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 16, 2022 10:02 AM PST
To: Lucy Copp <lcopp@scpr.org>
Subject: Re: NPR Los Angeles -- Interview Inquiry

Hi Lucy,

I'm sorry that I'm completely scheduled tomorrow.

Thanks and best wishes,

Steve Rosenthal

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: Lucy Copp <lcopp@scpr.org>
Sent: Wednesday, November 16, 2022 8:08 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: NPR Los Angeles -- Interview Inquiry

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Hi Dr. Rosenthal,

I'm a reporter at KPCC, an NPR affiliate station in Pasadena. I'm reaching out on behalf of our program AirTalk with Larry Mantle.

We're hoping to have a conversation on our program **tomorrow, Thursday from 10 am to 10:40 am PST** about puberty blockers from a medical standpoint. This conversation is coming from a recent NYT article that I sent to our team. We will likely have one of the reporters join. I'd love to see if you might be available for this discussion as well. If so, we can connect with you via Zoom, landline, or cell.

Let me know if this works for you and if so, I'd love to connect at your earliest convenience!

Thanks very much,

Lucy

Lucy Copp (she/her)
Associate Producer, AirTalk with Larry Mantle
Southern California Public Radio
474 S Raymond Avenue
Pasadena, CA 91105
401-952-2273 (cell)
kpcc.org | laist | @lucyacopp

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Wednesday, November 16, 2022 10:59 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: SOC8 and Bone

So very helpful. I have incorporated this.

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 16, 2022 9:34 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: SOC8 and Bone

Hi Maddie,

SOC8 does include specific content on bone health for kids. Specifically, SOC8 states that "Bone Mass" should be determined prior to starting Rx with GnRHa, and should be monitored during the course of GnRHa Rx. It also states there are no data to support use of GnRHa (as monotherapy) in someone older than 14 without posing a risk to bone health.

In terms of whether something was included as a formal recommendation vs. commented on in the text had to do with the Delphi process—e.g. a recommendation to not use GnRHa as a monotherapy after the age of 14 did not pass Delphi.

Here's what is the specific text related to Bone in SOC8:

When deciding on the duration of GnRHa monotherapy, all contributing factors should be considered, including factors such as pretreatment bone mass...

The **clinical course of the treatment**, e.g., the **development of bone mass during GnRHa treatment** and the adolescent's response to treatment, **can help to determine the length of GnRHa monotherapy.**

In addition, for **adolescents older than 14 years**, there are currently **no data** to inform HCPs **whether GnRHas can be administered as mono- therapy (and for what duration) without posing a significant risk to skeletal health.**

Also, it should be noted that the current version of the Endocrine Society CPG, co-sponsored by WPATH, also noted that bone studies should be obtained before starting GnRHa, and then every 1-2 yr.

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
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550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 16, 2022 4:44 PM PST
To: [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>
Subject: Re: Checking in…

Hi [redacted],

I just reviewed the recent emails related to CAGC Consultants I sent to [redacted], and it looks like they all pertained to [redacted] I'm not sure if you emailed her before today about [redacted]. I apologize if it slipped through. I just sent [redacted] an email and cc'd you, so hopefully we can get this going.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>
Sent: Wednesday, November 16, 2022 4:40 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Fw: Checking in…

Do we know where we are on this?

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted].[redacted]@ucsf.edu

From: [redacted]@gmail.com>
Sent: Wednesday, November 16, 2022 8:37 AM
To: [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Checking in…

Hey folks! Hope all is well. Just checking back in to see if there's any progress with getting me set up at UCSF. When you get a minute, let me know the latest.

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 16, 2022 5:42 PM PST
To: [redacted]@gmail.com>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Checking in…

Hi [redacted]

My apologies--I just got off the phone with [redacted] and we both realized that neither of us had taken the next step. I have now emailed [redacted], our Division's Administrator, and included the CAGC Director of Education job description you wrote along with the estimated time/week of work in that capacity. I will keep you posted as soon as I hear back from her.

Again, my apologies--I hope things will progress smoothly from here.

Thanks, and Happy Thanksgiving to you and all your family,

Steve

Stephen M. Rosenthal, M.D.
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@gmail.com>
Sent: Wednesday, November 16, 2022 8:37 AM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Checking in…

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, November 16, 2022 5:56 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: New CRC position

Thanks Steve.

[redacted], do you need more info than this?

Thanks,
[redacted]

--
[redacted], MSW
(Pronouns: they/them/theirs)
Clinical Research Coordinator
Division of Pediatric Endocrinology
University of California, San Francisco
550 16th St., San Francisco CA 94143
(707) 722-0478 | [redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 15, 2022 6:02:09 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],
[redacted].
Thanks,
Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
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Medical Director, Child and Adolescent Gender Center
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 5:42 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Is it possible to classify this as a fully remote position? If not, how specific of a location do you need?

Steve, can you confirm what location this position would be at? Do we have an address in the Pritzker building yet?

Thanks,
[redacted]
--

[redacted], ASW
(Pronouns: they/them/theirs)
Clinical Research Coordinator
UCSF Child & Adolescent Gender Center
(707) 722-0478 | [redacted]@ucsf.edu

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--
[redacted], MSW
(Pronouns: they/them/theirs)
Clinical Research Coordinator
Division of Pediatric Endocrinology
University of California, San Francisco
550 16th St., San Francisco CA 94143
(707) 722-0478 | [redacted]@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 3:15:36 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Hi [redacted],

Can you confirm the work location? HR is asking.

Best,

[redacted]

From: [redacted]
Sent: Monday, November 7, 2022 3:43 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Will do-I'll submit the request today. Thank you [redacted]

Best,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 7, 2022 3:41 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Yes, you can include me as the resume receiver and reviewer.

Thanks so much,
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Date: Monday, November 7, 2022 at 3:38 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Hi [redacted],

Phil approved the essential hire request on Monday, 10/31. Can I include you as the resume receiver and reviewer? If so, someone from Talent Acquisition will contact you and walk you through the brassring system and getting access to the recruitment request so you can manage it internally. Once I have this info I can submit the JD to HR so they can review it and provide their approval.

Best,

[redacted]

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 7, 2022 11:08 AM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Thank you for all your work to get my CSW position sorted out! I'm wanting to circle back to this CRC position now; do you know where things are at with this?

Best,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Date: Monday, October 17, 2022 at 3:56 PM
To: [redacted] <[redacted]@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>
Subject: Re: New CRC position

Confirmed!
Thanks,
Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
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Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
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Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, October 17, 2022 12:28 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Yes, you can review and organize the recruitment in BrassRing based on your position. I'll wait for Steve to confirm as well.

Best,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, October 17, 2022 12:26 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Thanks for keeping this ball rolling. Steve and I are planning to review the applicants together, if I'm allowed to based on my current position? I'll let Steve weigh in if there's anybody else he'd like to include in this, but not to my knowledge.

Thanks again,
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Date: Monday, October 17, 2022 at 12:13 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>

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Subject: RE: New CRC position

Hi [redacted],

I submitted the essential hire approval request. Once it's approved, I'll submit the new hire request to HR along with the JD. On the JD, I need to include who will receive and review the resumes in BrassRing, let me know if you would like for me to include someone else from Steve's team.

Best,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, October 13, 2022 4:09 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

I provided the information you requested to the best of my ability, below in red. I've also attached the Word doc, which I think I filled out correctly. Please let us know if more information is needed or any revisions need to be made.

Thanks!
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Date: Wednesday, October 12, 2022 at 12:05 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: RE: New CRC position

Hi Steve,

For new staff recruitments, we will need to submit an essential hire request to the department to approve. The information I need for that is included below. I'll also need you to complete the attached Job Description (JD). You'll also want to make sure you have enough funding to support this position. Please provide me with the funding source you would like to use?

Once you complete the JD and the essential hire request information, I'll submit it to the department for approval. After the department approves, I will then submit new hire requests to HR. They will then post the positions in BrassRing and you will manage the search process.

Info needed for essential hire request.

- Are these new or replacement positions
  Splitting already existing position
- Type
  - Full Time
  - Part Time
  - Contract
  - Limited
- Job Code 9335
- Job title Clinical Research Coordinator
- Briefly describe the position's responsibilities
  The CRC will execute, manage, and coordinate research protocols, as directed by the Clinical Research Supervisor and/or Principal Investigator (PI) for the Trans Youth Care Study. Duties may include, but will not be limited to: understanding the regulatory, institutional, sponsor and protocol requirements for the study; recruiting and screening potential participants; conducting all aspects of the informed consent process with potential participants; scheduling and managing study participant study visits; collecting data from participants' medical records and entering it into study database.
- %FTE for the position
  40%
- Supervisor name
  Stephen M. Rosenthal, MD
- Funding Source for Position*
  - *Only positions with 100%confirmed funding will be approved. Please list the confirmed funding sources - include percent effort, Fund-DeptID-Project and if applicable, start & end dates.*

  NIH Grant, award number A138395, Trans Youth Care study. 40% FTE through 1/31/2026

Let me know if you have any questions.

Best,

[redacted]

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, October 10, 2022 5:56 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: New CRC position

Hi [redacted],

We would like to initiate a job search for a new part-time CRC position at 40% effort. This will be someone that [redacted], cc'd here, and I will both supervise. Please let us know how to proceed. We will be happy to complete the job description portions.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
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email: Stephen.Rosenthal@ucsf.edu

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@gmail.com>
Sent: Thursday, November 17, 2022 4:12 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Couple of things

This Message Is From an External Sender
This message came from outside your organization.

Hey Steve,
I hope you're doing well. It was really good to see you and talk with you in Montreal!

I wanted to thank you for telling me about your wonderful whale-watching experience in Loreto. We have put it on our travel list, and we may even get out there this February/March 2023! We both love animals and nature, so this looks like a great encounter with both!

On a work related note, I have often cited your 2014 review article in JCEM about biological factors in gender identity. I was wondering if you have done or seen a more recent one that you like that you would share with me.

Hopefully we will see each other sometime in the near future with another in person GEI!
[redacted]

[redacted]Ph.D.
Co-Chair/Mental Health Chair, WPATH GEI
Past President, Georgia Psychological Association
Adjunct Assistant Professor, Dept. of Psychiatry & Behavioral Sciences,
Emory University School of Medicine
Licensed Psychologist
(He, him, his)

[redacted]

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 9:16 AM PST
To: [redacted] <[redacted]@ucsf.edu>; [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Hi [redacted]

I'm happy to do a 5 minute call/zoom with you and [redacted]. Any time tomorrow (Friday) from noon or later would work for me.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 8:19 AM
To: [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: your quotes for the NEJM release

Hi again, [redacted] is happy to have both of you contribute quotes to the release for the NEJM piece. Would you be able to get those to me by the Monday after Thanksgiving at latest? If easiest, we could also have a five-min call where you tell me what you'd generally like to say, and I can shape it into a quote (some folks find that process easier)-- whatever you prefer! Thanks, [redacted]

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

Obtained via CPRA by Judicial Watch, Inc.

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 9:18 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Sounds good. Could 12:30pm work for you both?

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 9:16 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>
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[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 9:18 AM PST
To: [redacted] <[redacted]@ucsf.edu>; [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Works for me.

Thanks,

Steve

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Sent: Thursday, November 17, 2022 9:18 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Sounds good. Could 12:30pm work for you both?

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 9:16 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

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Sent: Thursday, November 17, 2022 8:19 AM
To: [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: your quotes for the NEJM release

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[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 9:58 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

I'm main speaker at a conference in Calgary until 1:30 pm, so 12:30 won't work. I'm free from 3 pm to 5:30 pm, if anything in that time period works for the two of you.

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 9:18 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Works for me.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 9:18 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Sounds good. Could 12:30pm work for you both?

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 9:16 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Hi [redacted]

I'm happy to do a 5 minute call/zoom with you and [redacted]. Any time tomorrow (Friday) from noon or later would work for me.

Thanks,

Steve

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Stephen M. Rosenthal, M.D.
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 8:19 AM
To: [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: your quotes for the NEJM release

Hi again, [redacted] is happy to have both of you contribute quotes to the release for the NEJM piece. Would you be able to get those to me by the Monday after Thanksgiving at latest? If easiest, we could also have a five-min call where you tell me what you'd generally like to say, and I can shape it into a quote (some folks find that process easier)-- whatever you prefer! Thanks, [redacted]

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 10:11 AM PST
To: [redacted]@gmail.com>
Subject: Re: Couple of things
Attachment(s): "Rosenthal SM Nature Reviews Endocrinology TGD Youth_ 10 August 2021.pdf"

Hi [redacted],

Nice to hear from you, and great that we were able to be together in person in Montreal!

Very exciting that you may go to Loreto in Feb/March '23! I hope it works out! The Blue whales could be seen just off the coast Loreto. The gray whales were seen (and touched!) on the Pacific side of Baja—southwest of Loreto (near San Carlos, as I recall).

I have attached a more recent (2021) review I did for Nature Reviews Endocrinology that has an updated section on "Biological factors in gender identity".

I hope you have a wonderful Thanksgiving, and yes, it would be great to see each other in another in- person GEI!

Best wishes,

Steve

Stephen M. Rosenthal, M.D.
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@gmail.com>
Sent: Thursday, November 17, 2022 4:12 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Couple of things

This Message Is From an External Sender
This message came from outside your organization.

Hey Steve,
I hope you're doing well. It was really good to see you and talk with you in Montreal!

I wanted to thank you for telling me about your wonderful whale-watching experience in Loreto. We have put it on our travel list, and we may even get out there this February/March 2023! We both love animals and nature, so this looks like a great encounter with both!

On a work related note, I have often cited your 2014 review article in JCEM about biological factors in gender identity. I was wondering if you have done or seen a more recent one that you like that you would share with me.

Hopefully we will see each other sometime in the near future with another in person GEI!
[redacted]

[redacted]Ph.D.
Co-Chair/Mental Health Chair, WPATH GEI
Past President, Georgia Psychological Association
Adjunct Assistant Professor, Dept. of Psychiatry & Behavioral Sciences,
Emory University School of Medicine
Licensed Psychologist
(He, him, his)

[redacted]

Obtained via CPRA by Judicial Watch, Inc.

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 10:12 AM PST
To: [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Yes, that works for me.

Thanks

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] [redacted] <[redacted].[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 9:58 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

I'm main speaker at a conference in Calgary until 1:30 pm, so 12:30 won't work. I'm free from 3 pm to 5:30 pm, if anything in that time period works for the two of you.

[redacted], Ph.D.
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1825 Fourth St., Sixth Floor
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e-mail: [redacted].[redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 9:18 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Works for me.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
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Medical Director, Child and Adolescent Gender Center
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From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 9:18 AM

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To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Sounds good. Could 12:30pm work for you both?

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 9:16 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 8:19 AM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: your quotes for the NEJM release

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[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 10:44 AM PST
To: [redacted], [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

No this will do-thank you both.

From: [redacted], [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, November 16, 2022 5:57 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: New CRC position

Thanks Steve.

[redacted], do you need more info than this?

Thanks,
[redacted]

--
[redacted], MSW
(Pronouns: they/them/theirs)
Clinical Research Coordinator
Division of Pediatric Endocrinology
University of California, San Francisco
550 16th St., San Francisco CA 94143
(707) 722-0478 | [redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 15, 2022 6:02:09 PM
To: [redacted], [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],
[redacted]
Thanks,
Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted], [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 5:42 PM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Is it possible to classify this as a fully remote position? If not, how specific of a location do you need?

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Steve, can you confirm what location this position would be at? Do we have an address in the Pritzker building yet?

Thanks,
[redacted]
--

[redacted], ASW
(Pronouns: they/them/theirs)
Clinical Research Coordinator
UCSF Child & Adolescent Gender Center
(707) 722-0478 | [redacted]@ucsf.edu

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--
[redacted], MSW
(Pronouns: they/them/theirs)
Clinical Research Coordinator
Division of Pediatric Endocrinology
University of California, San Francisco
550 16th St., San Francisco CA 94143
(707) 722-0478 | [redacted]@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 15, 2022 3:15:36 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Hi [redacted],

Can you confirm the work location? HR is asking.

Best,

[redacted]

From: [redacted]
Sent: Monday, November 7, 2022 3:43 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Will do-I'll submit the request today. Thank you [redacted]

Best,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 7, 2022 3:41 PM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted]

Yes, you can include me as the resume receiver and reviewer.

Thanks so much,
[redacted]

From: [redacted]@ucsf.edu>
Date: Monday, November 7, 2022 at 3:38 PM
To: [redacted] <[redacted]@ucsf.edu>

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Obtained via CPRA by Judicial Watch, Inc.

Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Hi [redacted],

[redacted] approved the essential hire request on Monday, 10/31. Can I include you as the resume receiver and reviewer? If so, someone from Talent Acquisition will contact you and walk you through the brassring system and getting access to the recruitment request so you can manage it internally. Once I have this info I can submit the JD to HR so they can review it and provide their approval.

Best,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 7, 2022 11:08 AM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Thank you for all your work to get my CSW position sorted out! I'm wanting to circle back to this CRC position now; do you know where things are at with this?

Best,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Date: Monday, October 17, 2022 at 3:56 PM
To: [redacted]@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>
Subject: Re: New CRC position

Confirmed!
Thanks,
Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

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Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Monday, October 17, 2022 12:28 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Yes, you can review and organize the recruitment in BrassRing based on your position. I'll wait for Steve to confirm as well.

Best,

[redacted]

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, October 17, 2022 12:26 PM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

Thanks for keeping this ball rolling. Steve and I are planning to review the applicants together, if I'm allowed to based on my current position? I'll let Steve weigh in if there's anybody else he'd like to include in this, but not to my knowledge.

Thanks again,
[redacted]

From: [redacted]@ucsf.edu>
Date: Monday, October 17, 2022 at 12:13 PM
To: [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: New CRC position

Hi [redacted],

I submitted the essential hire approval request. Once it's approved, I'll submit the new hire request to HR along with the JD. On the JD, I need to include who will receive and review the resumes in BrassRing, let me know if you would like for me to include someone else from Steve's team.

Best,

[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, October 13, 2022 4:09 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: New CRC position

Hi [redacted],

I provided the information you requested to the best of my ability, below in red. I've also attached the Word doc, which I think I filled out correctly. Please let us know if more information is needed or any revisions need to be made.

Thanks!
[redacted]

From: [redacted]@ucsf.edu>
Date: Wednesday, October 12, 2022 at 12:05 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: RE: New CRC position

Hi Steve,

For new staff recruitments, we will need to submit an essential hire request to the department to approve. The information I need for that is included below. I'll also need you to complete the attached Job Description (JD). You'll also want to make sure you have enough funding to support this position. Please provide me with the funding source you would like to use?

Once you complete the JD and the essential hire request information, I'll submit it to the department for approval. After the department approves, I will then submit new hire requests to HR. They will then post the positions in BrassRing and you will manage the search process.

Info needed for essential hire request.

- Are these new or replacement positions
  Splitting already existing position
- Type
  - Full Time
  - Part Time
  - Contract
  - Limited
- Job Code 9335
- Job title Clinical Research Coordinator
- Briefly describe the position's responsibilities

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The CRC will execute, manage, and coordinate research protocols, as directed by the Clinical Research Supervisor and/or Principal Investigator (PI) for the Trans Youth Care Study. Duties may include, but will not be limited to: understanding the regulatory, institutional, sponsor and protocol requirements for the study; recruiting and screening potential participants; conducting all aspects of the informed consent process with potential participants; scheduling and managing study participant study visits; collecting data from participants' medical records and entering it into study database.

- %FTE for the position
  40%
- Supervisor name
  Stephen M. Rosenthal, MD
- Funding Source for Position*
  - *Only positions with 100% confirmed funding will be approved. Please list the confirmed funding sources - include percent effort, Fund-DeptID-Project and if applicable, start & end dates.*

  NIH Grant, award number A138395, Trans Youth Care study. 40% FTE through 1/31/2026

Let me know if you have any questions.

Best,

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, October 10, 2022 5:56 PM
To: [redacted]@ucsf.edu>
Cc: [redacted], [redacted] <[redacted]@ucsf.edu>
Subject: New CRC position

Hi [redacted],

We would like to initiate a job search for a new part-time CRC position at 40% effort. This will be someone that [redacted], cc'd here, and I will both supervise. Please let us know how to proceed. We will be happy to complete the job description portions.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
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Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Lucy Copp <lcopp@scpr.org>
Sent: Thursday, November 17, 2022 2:03 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: NPR Los Angeles -- Interview Inquiry

This Message Is From an External Sender
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Hi Dr. Rosenthal,

We are trying to reschedule this conversation on puberty blockers for this Monday at 9:20 am PST. Might you be available then? If so let me know and perhaps we can jump on a really brief call to discuss.

Thanks so much,

Lucy

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 16, 2022 10:02 AM
To: Lucy Copp <lcopp@scpr.org>
Subject: Re: NPR Los Angeles -- Interview Inquiry

[External Content] This message is from an external source. Please exercise caution when opening attachments or links.
Hi Lucy,

I'm sorry that I'm completely scheduled tomorrow.

Thanks and best wishes,

Steve Rosenthal

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
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Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: Lucy Copp <lcopp@scpr.org>
Sent: Wednesday, November 16, 2022 8:08 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: NPR Los Angeles -- Interview Inquiry

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Hi Dr. Rosenthal,

I'm a reporter at KPCC, an NPR affiliate station in Pasadena. I'm reaching out on behalf of our program AirTalk with Larry Mantle.

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Obtained via CPRA by Judicial Watch, Inc.

We're hoping to have a conversation on our program **tomorrow, Thursday from 10 am to 10:40 am PST** about puberty blockers from a medical standpoint. This conversation is coming from a recent NYT article that I sent to our team. We will likely have one of the reporters join. I'd love to see if you might be available for this discussion as well. If so, we can connect with you via Zoom, landline, or cell.

Let me know if this works for you and if so, I'd love to connect at your earliest convenience!

Thanks very much,

Lucy

Lucy Copp (she/her)
Associate Producer, AirTalk with Larry Mantle
Southern California Public Radio
474 S Raymond Avenue
Pasadena, CA 91105
401-952-2273 (cell)
kpcc.org |laist | @lucyacopp

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 2:06 PM PST
To: Lucy Copp <lcopp@scpr.org>
Subject: Re: NPR Los Angeles -- Interview Inquiry

Hi Lucy,

I'm traveling all of next week and unfortunately not available.

Best wishes,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
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email: Stephen.Rosenthal@ucsf.edu

From: Lucy Copp <lcopp@scpr.org>
Sent: Thursday, November 17, 2022 2:03 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: NPR Los Angeles -- Interview Inquiry

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Lucy

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 16, 2022 10:02 AM
To: Lucy Copp <lcopp@scpr.org>
Subject: Re: NPR Los Angeles -- Interview Inquiry

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Thanks and best wishes,

Steve Rosenthal

Stephen M. Rosenthal, M.D.
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Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: Lucy Copp <lcopp@scpr.org>
Sent: Wednesday, November 16, 2022 8:08 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: NPR Los Angeles -- Interview Inquiry

This Message Is From an External Sender
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Hi Dr. Rosenthal,

I'm a reporter at KPCC, an NPR affiliate station in Pasadena. I'm reaching out on behalf of our program AirTalk with Larry Mantle.

We're hoping to have a conversation on our program **tomorrow, Thursday from 10 am to 10:40 am PST** about puberty blockers from a medical standpoint. This conversation is coming from a recent NYT article that I sent to our team. We will likely have one of the reporters join. I'd love to see if you might be available for this discussion as well. If so, we can connect with you via Zoom, landline, or cell.

Let me know if this works for you and if so, I'd love to connect at your earliest convenience!

Thanks very much,

Lucy

Lucy Copp (she/her)
Associate Producer, AirTalk with Larry Mantle
Southern California Public Radio
474 S Raymond Avenue
Pasadena, CA 91105
401-952-2273 (cell)
kpcc.org | laist | @lucyacopp

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From: Lucy Copp <lcopp@scpr.org>
Sent: Thursday, November 17, 2022 2:07 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: NPR Los Angeles -- Interview Inquiry

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Ok, thanks for letting me know. Safe travels.

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To: Lucy Copp <lcopp@scpr.org>
Subject: Re: NPR Los Angeles -- Interview Inquiry

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Hi Lucy,

I'm traveling all of next week and unfortunately not available.

Best wishes,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

San Francisco CA 94143-0434
Pronouns: he/him/his

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email: Stephen.Rosenthal@ucsf.edu

From: Lucy Copp <lcopp@scpr.org>
Sent: Thursday, November 17, 2022 2:03 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: NPR Los Angeles -- Interview Inquiry

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Hi Dr. Rosenthal,

We are trying to reschedule this conversation on puberty blockers for this Monday at 9:20 am PST. Might you be available then? If so let me know and perhaps we can jump on a really brief call to discuss.

Thanks so much,

Lucy

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 16, 2022 10:02 AM
To: Lucy Copp <lcopp@scpr.org>

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Subject: Re: NPR Los Angeles -- Interview Inquiry

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Thanks and best wishes,

Steve Rosenthal

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 2:09 PM PST
To: Lucy Copp <lcopp@scpr.org>
Subject: Re: NPR Los Angeles -- Interview Inquiry

Thank you, and Happy Thanksgiving,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
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Let me know if this works for you and if so, I'd love to connect at your earliest convenience!

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kpcc.org |laist | @lucyacopp

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 2:55 PM PST
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
CC: [redacted] <[redacted]@ucsf.edu>
Subject: Re: PCMA Case # 00295879 - CRC Opening

Hi [redacted],

The time for the 16 hr/week is flexible. I'm not sure what is meant by "5 openings". Hopefully, [redacted] can respond.

Thanks,

Steve

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 2:51 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
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Also can I get a little more information on the shift. Are there certain days they need to be available? Could we say something like Monday – Friday, 16 hours/week.

[redacted]
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From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 2:58 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: RE: PCMA Case # 00295879 - CRC Opening

Hi Dr. Rosenthal,

[redacted] is referring to the recruitment being requested is to fill 5 vacancies. Could you confirm that you are trying to fill 5 open CRC roles?

Best,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 2:56 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: Re: PCMA Case # 00295879 - CRC Opening

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 3:01 PM PST
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: PCMA Case # 00295879 - CRC Opening

To the best of my knowledge, we are looking to fill one part-time CRC at 0.4 FTE.

Thanks,

Steve

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Cc: [redacted] <[redacted]@ucsf.edu>
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Hi [redacted] and [redacted],

We are only trying to fill one CRC role for 16 hrs/week.

Thanks,
[redacted]

From: [redacted]@ucsf.edu>
Date: Thursday, November 17, 2022 at 2:58 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>, [redacted]@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>
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Subject: Re: your quotes for the NEJM release

[redacted]

Does that work for you?

Thanks,

Steve

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Subject: Re: your quotes for the NEJM release

Yes, that works for me.

Thanks

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Sent: Thursday, November 17, 2022 9:58 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

I'm main speaker at a conference in Calgary until 1:30 pm, so 12:30 won't work. I'm free from 3 pm to 5:30 pm, if anything in that time period works for the two of you.

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 9:18 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Works for me.

Thanks,

Steve

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Sent: Thursday, November 17, 2022 9:18 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Sounds good. Could 12:30pm work for you both?

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 9:16 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Hi [redacted]

I'm happy to do a 5 minute call/zoom with you and [redacted]. Any time tomorrow (Friday) from noon or later would work for me.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
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From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 8:19 AM
To: [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: your quotes for the NEJM release

Hi again, Lurie is happy to have both of you contribute quotes to the release for the NEJM piece. Would you be able to get those to me by the Monday after Thanksgiving at latest? If easiest, we could also have a five-min call where you tell me what you'd generally like to say, and I can shape it into a quote (some folks find that process easier)-- whatever you prefer! Thanks, [redacted]

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 3:02 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: RE: PCMA Case # 00295879 - CRC Opening

Thank you! I just posted the req.

[redacted]
Pronouns: she, her, hers
Talent Acquisition Partner | UC San Francisco HR, Campus
T: 415-514-1110 | [redacted]@ucsf.edu
Clifton Strengths: Responsibility, Discipline, Input, Developer, Includer

http://www.ucsfhr.ucsf.edu/careers/
Follow us on Facebook & Twitter @ucsfcareers

UCPath
Learn more at ucpath.ucsf.edu.

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 3:01 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: PCMA Case # 00295879 - CRC Opening

To the best of my knowledge, we are looking to fill one part-time CRC at 0.4 FTE.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall; Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 2:58 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: RE: PCMA Case # 00295879 - CRC Opening

Hi Dr. Rosenthal,

[redacted] is referring to the recruitment being requested is to fill 5 vacancies. Could you confirm that you are trying to fill 5 open CRC roles?

Best,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>

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Sent: Thursday, November 17, 2022 2:56 PM
To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: PCMA Case # 00295879 - CRC Opening

Hi [redacted],

The time for the 16 hr/week is flexible. I'm not sure what is meant by "5 openings". Hopefully, [redacted] can respond.

Thanks,

Steve

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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 2:51 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: PCMA Case # 00295879 - CRC Opening

Hello,

I just wanted to check on a few things before I post this CRC position.

The pcma case says this is for 5 openings, is that correct?

Also can I get a little more information on the shift. Are there certain days they need to be available? Could we say something like Monday – Friday, 16 hours/week.

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To: [redacted], [redacted] <[redacted]@ucsf.edu>
Subject: Fw: Your UCSF Campus Recruitment Posted! Clinical Research Coordinator (Req #70499BR)

Hi [redacted],

FYI.

Thanks,

Steve

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Things to remember:

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- Maintain all interview documents for 4 years
- Affirmative Action Goal: Male,White: UCSF's commitment to affirmative action and in compliance with our obligations as a federal contractor, the University annually identifies certain job groups with placement goals* that require the University to engage in additional outreach to expand the pool of applicants. It will be used by you and your recruiter to assemble a competitive and diverse candidate pool.

I look forward to speaking with you at our recruitment kick-off call.
Best Regards,
[redacted]
[redacted]@ucsf.edu

Additional resources:

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From: [redacted], [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 3:05 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Your UCSF Campus Recruitment Posted! Clinical Research Coordinator (Req #70499BR)

Yay! I'm supposed to be receiving an email soon to set up my BrassRing account so I can keep track of this, but am currently waiting on that.

Thanks for passing along!

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To: [redacted], [redacted] <[redacted]@ucsf.edu>
Subject: Fw: Your UCSF Campus Recruitment Posted! Clinical Research Coordinator (Req #70499BR)

Hi [redacted],

FYI.

Thanks,

Steve

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 3:08 PM PST
To: [redacted] <[redacted]@ucsf.edu>; Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Protest at Gateway Building 11/17/2022

Hi [redacted]

Thanks for letting us know. I'm sure the situation was not helped by the recent highly biased New York Times article about puberty blockers from Monday.

[redacted] and [redacted],
Please respond to [redacted] questions.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
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email: Stephen.Rosenthal@ucsf.edu

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Sent: Thursday, November 17, 2022 3:03 PM
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Subject: Protest at Gateway Building 11/17/2022

Hi All,

I happened to run into Serene today, and she told me that there were 3-4 protestors in front of the Gateway Building around lunch time. She's not sure how long they were there. I came in through the employee entrance so did not see them at all. Serene said they were definitely protesting gender care and puberty blockers, had matching purple shirts and seemed religious. [redacted]

Was UC PD aware of these protestors? Is there a protocol for handling protestors in front of our clinic buildings? Just want to be sensitive of our patients who are coming in to be seen - really mostly worried about how seeing these protestors will affect our transgender and gender diverse youth.

Thanks!
[redacted]

[redacted], MD, MPH, MAS
Assistant Professor of Pediatrics and of Medicine
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Sent: Thursday, November 17, 2022 3:08 PM PST
To: [redacted], [redacted] <[redacted]@ucsf.edu>
Subject: Re: Your UCSF Campus Recruitment Posted! Clinical Research Coordinator (Req #70499BR)

Yay!

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Date: Thursday, November 17, 2022 at 3:02 PM
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Subject: Fw: Your UCSF Campus Recruitment Posted! Clinical Research Coordinator (Req #70499BR)

Hi [redacted],

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Subject: Re: Protest at Gateway Building 11/17/2022

Thanks for this update.

Steve

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Subject: Re: Protest at Gateway Building 11/17/2022

Hi, I just connected with PD about this group. They confirmed there were 4 of them, and signs say "First Do No Harm," "democrats against puberty blockers" "transitioning is not suicide prevention" "don't trans the gay away." PD is monitoring their presence, and noted that at this point they are on public property and not blocking building ingress/egress.

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Was UC PD aware of these protestors? Is there a protocol for handling protestors in front of our clinic buildings? Just want to be sensitive of our patients who are coming in to be seen - really mostly worried about how seeing these protestors will affect our transgender and gender diverse youth.

Thanks!
~[redacted]

[redacted] MD, MPH, MAS
Assistant Professor of Pediatrics and of Medicine
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Assistant Medical Director, Child and Adolescent Gender Center
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To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Protest at Gateway Building 11/17/2022

I can think of some other things I'd like to do, too...

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, November 17, 2022 3:16 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Protest at Gateway Building 11/17/2022

One thing I'd like to do next time we learn of one of these is show up with a boombox and play Lou [redacted] "Metal Machine Music" at max volume on loop.

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, November 17, 2022 3:13 PM
To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Protest at Gateway Building 11/17/2022

Hi all. I am glad PD is monitoring. I think we are needing to close the loop on what actions to take when such protests occur, such as notifying CAGC staff, our ad-hoc group, and any other action steps to be taken.

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That's for verbal discussion over cocktails, which I hope happens soon and we stop having to spend all of this energy dealing with this garbage.

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email: Stephen.Rosenthal@ucsf.edu

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Sent: Thursday, November 17, 2022 3:16 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Protest at Gateway Building 11/17/2022

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Sent: Thursday, November 17, 2022 3:21 PM PST
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Protest at Gateway Building 11/17/2022

Sometime after December 11 works for me!

Steve

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At a bare minimum we need to make sure that we are notified by PD when these things are noticed. The question is whether PD actually knew about this a priori, or if [redacted] called PD, and PD sent a car over and reported back.

We would then have measures in place to act to protect patients and staff etc....

Also, if word happens to get out to certain community segments with experience in counter-protesting, so be it

---

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Sent: Thursday, November 17, 2022 3:48 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Yes, will send over a Zoom invite-- let's go for 3:45pm. Thanks!
[redacted]

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

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To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
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Great. in my book for 3:45.

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Subject: Fwd: Puberty blockers & Consequences
Attachment(s): "Guss & Gordon-22-Pubertal Blockade and Subsequent Gender-Affirming Therapy - Comment on Nos etal-22.pdf","Nos etal-22-Association of Gonadotropin-Releasing Hormone Analogue Use With Subsequent Use of Gender-Affirming Hormones Among Transgender Adolescents.pdf"

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Had you seen these?

Thoughts?

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Date: Thu, Nov 3, 2022 at 6:09 AM
Subject: Puberty blockers & Consequences
To: <SEXNET@listserv.it.northwestern.edu>

This may be of interest for some Sexnetters. It contradicts at least my clinical experience.

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Regards

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[redacted]
Head, Practice for Sexual Medicine
Dreiecksplatz 5
D-24105 Kiel; Germany
Tel: [redacted]
Fax: [redacted]
Mail: [redacted]@sexualmedizin-kiel.de
Homepage: https://urldefense.com/v3/__http://www.Sexualmedizin-kiel.de__;!!Dq0X2DkFhyF93HkjWTBQKhk!TMltl4_S8n9b029f-dVF1zKTT7keR-6iElJWU14aGwcOnd_4-iudM4qVQZqwsgkPUt4QV7QdwovAVFEKhl51MNV9epVfbl1rd6PZ8hLp0WEz$
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[redacted]
Professor Emeritus
The Institute for Sexual and Gender Health
University of Minnesota Medical School
Family Medicine and Community Health
med.umn.edu/sexualhealth

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Invited Commentary | Pediatrics

Pubertal Blockade and Subsequent Gender-Affirming Therapy

Carly Guss, MD, MPH; Catherine M. Gordon, MD, MS

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For youth who identify as transgender or are unsure and wish to explore possibilities before the development of permanent secondary sex characteristics, use of a gonadotropin-releasing hormone analogue (GnRHa) is a key medical option. Sometimes colloquially called "puberty blockers," they have been used safely for decades in children with precocious puberty[1] and endometriosis,[2] among other medical indications. Multiple professional societies now endorse pubertal blockade for youth with gender dysphoria.[3,4] Recently, the use of GnRHa has received attention because of legislated concerns regarding the medical and surgical treatment of transgender youth, including criminalizing the provision of this care in some states.[5] Without evidence, the assumption has been made that GnRHa treatment leads to increased ultimate use of gender-affirming therapy (GAT) in transgender youth and that prescription of a GnRHa inappropriately advances the decision to start GAT. The article by Nos et al[6] provides data to the contrary—that this therapy can be offered both for mental health and cosmetic benefits without the concern of increasing the subsequent use of GAT.

An understanding of the medical management of a transgender child or adolescent is needed to appreciate the issues at hand.[3,4,7] A GnRHa is more potent than native GnRH and produces initial stimulation of pituitary gonadotrophs, with increased secretion of follicle-stimulating hormone, luteinizing hormone, and gonadal hormones, followed by downregulation of the pituitary-gonadal axis. As sex steroid secretion is inhibited, the development of pubertal changes ceases. Pubertal blockade with a GnRHa buys time for a child or adolescent, pausing puberty and allowing for the exploration of gender identity. Initiated early in puberty, the GnRHa delays the development of irreversible pubertal changes and, in some cases, eliminates the need for subsequent surgery. GnRHa therapy is reversable; discontinuation leads to prompt resumption of the pituitary-gonadal axis. Although pubertal blockade and GAT are often prescribed as complementary approaches, they are separate phases in transgender treatment.[3]

Through a retrospective cohort study of billing and pharmacy records, Nos and colleagues[6] explored the timely question of whether GnRHa use was associated with subsequent use of GAT among transgender and gender-diverse adolescents. They reviewed data between 2009 and 2018 from the US Military Healthcare System. Participants had at least 2 transgender-related encounters, with the first occurring between ages 10 and 17 years, and at least 1 encounter after the participant's 14th birthday (the earliest a clinician would start GAT according to current guidelines).[3,4,7] The sample included 434 adolescents, with 71.9% assigned female at birth and 69.1% having an enlisted insurance sponsor. Younger patients (aged 10-13 years) were more likely to start GnRHa therapy than older (aged 14-17 years) patients: 57.1% vs 10.1%. Patients who were assigned male at birth were more likely to receive GnRHa than those assigned female but were not more likely to be prescribed gender-affirming hormones. In fact, patients who were prescribed GnRHa were less likely to start GAT within 6 years of the first encounter than those who were not (hazard ratio, 0.52; 95% CI, 0.37-0.71). For clinicians, the salient point is that the prescription of a GnRHa did not imply the ensured subsequent use of GAT. The findings suggest that clinicians can offer GnRHa therapy without the concern of influencing the future use of GAT. The decision to initiate GnRHa therapy represents an independent therapeutic decision for a clinician, ideally working in concert with a multidisciplinary team of both medical and mental health clinicians.[5]

Limitations of the study of Nos and colleagues[6] merit discussion. They included younger children compared with earlier studies, which is a strength of the study, but as younger age was associated with higher GnRHa discontinuation rates, this could explain the finding. However, overall,

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few patients discontinued treatment. Data were also extracted from an administrative database that did not afford information on the reasons why a clinician initiated therapy or not, and why patients chose to continue or discontinue the treatment. Patients could have obtained prescriptions outside of the Military Healthcare System that were not captured. However, the high costs out of pocket or through private insurance make this possibility unlikely. Lack of official approval for GAT coverage before 2016 may have influenced the decisions of patients or clinicians. Finally, there may be inherent biases among military medical personnel regarding gender identity and potential reluctance to provide treatment. The reasons could be personal ones or related to a lack of expertise. Replication of these results in a different study setting will be important to expand the generalizability of the current findings.

A question that arises in the course of transgender care is whether GnRHa therapy has long-term adverse medical consequences, including effects on bone health. More than one-half of an individual's bone density is acquired during adolescence, and transgender youth assigned male at birth are known to be at higher risk for low bone density even before GnRHa therapy.[7] Understanding whether GnRHa use is associated with fracture risk will be the critical long-term question that must be answered in future studies. In pediatrics, we are often left needing to weigh risks vs benefits, with limited available evidence, and needing to prescribe medications off-label. For the adolescent who goes on to receive GAT, theoretically and anecdotally, reintroduction of sex steroids appears to mediate skeletal gains, especially for transgender male individuals. In considering bone health and other health outcomes, optimizing bone density must be balanced with the known benefits of GnRHa for gender dysphoria, including decreased suicidal ideation.[6] Concerns about skeletal losses become less significant in an adolescent with active suicidal ideations. Although the significance of the risks may be unclear, there is strong evidence regarding the benefits of GnRHa in transgender youth: it can be a life-changing and lifesaving treatment for a vulnerable population who is at high risk for anxiety, depression, and suicide.[4,5,7]

The treatment decisions for transgender youth can be complex, with many factors that need to be considered. The novel findings provided by the study of Nos and colleagues[6] add to the growing body of work demonstrating that GnRHa therapy is a safe and necessary component of transgender care, especially for children or adolescents with gender dysphoria. Their results emphasize that use of GnRHa and subsequent GAT are different phases of treatment, and their use should be guided by independent decisions that a clinician makes separately. From a cosmetic standpoint, it is much easier to treat a patient if pubertal changes have only just begun to develop, and gender dysphoria subsides as the worry of continued development of secondary sex characteristics comes to a halt. We hope that an enhanced understanding of transgender medical management, including the separate phases of therapy, and how a GnRHa works therapeutically, will help to dispel myths. The study by Nos and colleagues[6] is hopefully one step forward in that direction. One phase of transgender treatment does not and should not dictate the next phase, thereby enabling clinicians to individualize care. Perhaps, even moving away from the term "puberty blocker" and instead describing mechanistically and clinically how these agents work will help return the focus of gender care to what matters most: the health and wellness of the child or adolescent.

ARTICLE INFORMATION

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Corresponding Author: Catherine M. Gordon, MD, MS, Department of Pediatrics, Baylor College of Medicine, 1100 Bates Ave, Houston, TX 77030 (catherine.gordon@bcm.edu).

Author Affiliations: Division of Adolescent/Young Adult Medicine, Boston Children's Hospital, Boston, Massachusetts (Guss); Division of Endocrinology, Boston Children's Hospital, Boston, Massachusetts (Guss); Department of Pediatrics, Harvard Medical School, Boston, Massachusetts (Guss); Department of Pediatrics,

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Baylor College of Medicine, Houston, Texas (Gordon).

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Original Investigation | Pediatrics

Association of Gonadotropin-Releasing Hormone Analogue Use With Subsequent Use of Gender-Affirming Hormones Among Transgender Adolescents

Andrea L. Nos, MD; David A. Klein, MD, MPH; Terry A. Adirim, MD, MPH; Natasha A. Schvey, PhD; Elizabeth Hisle-Gorman, MSW, PhD; Apryl Susi, MS; Christina M. Roberts, MD, MPH

Abstract

IMPORTANCE Gonadotropin-releasing hormone analogue (GnRHa) use during puberty improves mental health among transgender and gender-diverse (TGD) adolescents. In previous studies, most (96.5%-98.1%) TGD adolescents who started GnRHa subsequently started gender-affirming hormones (GAH), raising concerns that GnRHa use promotes later use of GAH.

OBJECTIVE To determine whether GnRHa use among TGD adolescents is associated with increased subsequent GAH use.

DESIGN, SETTING, AND PARTICIPANTS This is a retrospective cohort study of administrative records collected between 2009 and 2018. The current analysis was completed in August 2022. Participants were enrolled in the US Military Healthcare System (MHS) with an initial TGD-related encounter occurring between ages 10 and 17 years.

EXPOSURES GnRHa use.

MAIN OUTCOMES AND MEASURES Initiation of GAH.

RESULTS The 434 patients were a mean (SD) of 15.4 (1.6) years old at the time of their first TGD-related encounter; 312 (71.9%) were assigned female at birth, and 300 (69.1%) had an enlisted insurance sponsor. GnRHa use was more common among patients who were assigned male at birth (28 patients [23.0%]) than those assigned female (42 patients [13.5%]), but GAH use was not. Socioeconomic status was not associated with GnRHa or GAH use. Compared with older patients (aged 14-17 years), those who were younger (aged 10-13 years) at the time of the initial TGD-related encounter had a higher rate of GnRHa use (32 patients [57.1%] vs 38 patients [10.1%]) and a longer median time to starting GAH. The median interval from the date of the initial encounter to starting GAH decreased over time, from 2.3 years (95% CI, 1.7-2.8 years) between October 2009 and December 2014 to 0.6 years (95% CI, 0.5-0.6 years) between September 2016 and April 2018. Patients who were prescribed GnRHa had a longer median time to starting GAH (1.8 years; 95% CI, 1.1-2.4 years) than patients who were not (1.0 years; 95% CI, 0.8-1.2 years) and were less likely to start GAH during the 6 years after their first TGD-related encounter (hazard ratio, 0.52; 95% CI, 0.37-0.71). Among 54 younger (aged 10-13 years) patients who were not eligible to start GAH at their first encounter, GnRHa use was associated with a longer median time to starting GAH, but age at the first TGD-related visit was not.

CONCLUSIONS AND RELEVANCE In this cohort study of TGD adolescents, GnRHa use was not associated with increased subsequent GAH use. These findings suggest that clinicians can offer the benefits of GnRHa treatment without concern for increasing rates of future GAH use.

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Key Points

Question Is there an association between use of gonadotropin-releasing hormone analogue and subsequent use of gender-affirming hormones among transgender and gender-diverse adolescents?

Findings In this cohort study of 434 adolescents, there was no significant association between gonadotropin-releasing hormone use and subsequent initiation of gender-affirming hormones.

Meaning These findings suggest that clinicians can offer gonadotropin-releasing hormone analogues to transgender and gender-diverse adolescents during pubertal development for mental health and cosmetic benefits without an increased likelihood of subsequent use of gender-affirming hormones.

+ Invited Commentary

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Introduction

In the US, 1.8% of high school students identify as transgender, with an increasing number of children and adolescents seeking gender identity–specific health care in recent years.[1-4] Transgender and gender-diverse (TGD) youth are at high risk for depression, anxiety, self-harm, and suicidality.[1,5-7] This is likely related to gender dysphoria, family rejection, and increased exposure to bullying, discrimination, harassment, violence, and social isolation.[1,6]

Multiple medical societies and evidence-based treatment guidelines support the use of gonadotropin-releasing hormone analogues (GnRHa) to reversibly suppress further pubertal development in peripubertal youth with gender dysphoria.[8-11] This treatment is associated with improvements in global functioning, depression, suicidal ideation, and overall behavioral and emotional problems among youth with gender dysphoria.[12-16] Treatment with GnRHa can improve gender dysphoria by reversibly halting development of secondary sex characteristics that are not consistent with the patient's experienced gender. Relieving the pressure associated with additional pubertal development can also give young adolescents more time to fully confirm their gender identities before making a decision about initiating further gender-affirming treatment with irreversible effects.[8,9,17] Pubertal suppression may also affect cosmetic outcomes if the patient elects to progress to gender-affirming hormones, decreasing the need for certain future interventions, such as mastectomies in people with trans-masculine gender identities and facial feminization in people with trans-feminine gender identities.[18] However, the use of GnRHa for pubertal suppression is associated with short-term physical symptoms, such as headaches, hot flashes, and fatigue, and long-term risks such as decreased bone mineral density and changes in body composition. Use of GnRHa in early puberty followed by treatment with estrogen can also impair fertility and complicate future vaginoplasty.[19-22] The benefits of GnRHa treatment in postpubertal youth are not as clear. Assisting patients and families with assessment of the risks and benefits of treatment and managing adverse effects that occur is an important part of caring for transgender youth.

In prior studies[4,20,23] of gender-affirming medical care for TGD adolescents, 96.5% to 98.1% of individuals who started GnRHa subsequently used gender-affirming hormones. This high rate has led some clinicians, judges, and legislators to express concerns that initiation of GnRHa treatment in young adolescents does not serve as a pause in pubertal development, but instead inappropriately advances the decision to start gender-affirming hormones to a younger age when the adolescent has not yet completed the cognitive development required to assent to this treatment.[8,24-27] Guidelines for gender-affirming care suggest that most adolescents do not reach cognitive maturity until age 15 to 16 years, after most have completed puberty and can no longer obtain maximum benefit from GnRHa treatment.[8]

In the United Kingdom, a court ruled that GnRHa treatment could not be administered to transgender patients younger than 16 years without a court order because they assert that this treatment inevitably leads to use of gender-affirming hormones. This ruling also suggested that gender-affirming care for patients aged 16 and 17 years old should be restricted as well.[26] In the US, 3 states have outlawed all gender-affirming medical care for minors, 1 state government has taken administrative action to classify gender-affirming medical care for minors as child abuse, and 16 state public medical insurance programs for those with limited income or resources (Medicaid) do not pay for gender-affirming medical care. An additional 19 state legislatures are considering laws to make some or all aspects of gender-affirming medical care for minors illegal.[28,29]

It is unknown whether GnRHa treatment among TGD youth leads to an increase in subsequent use of gender-affirming hormones or whether the high continuation rate seen in previous studies reflects the natural history of gender dysphoria among adolescents or the rigorous screening process used before administration of GnRHa in previous studies. The purpose of our study is to compare the rates of gender-affirming hormone initiation between patients who are treated with GnRHa and those who are not treated with GnRHa. We hypothesized that TGD youth who were treated with

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GnRHa would not have a higher rate of future gender-affirming hormone use compared with TGD youth who were not treated with GnRHa.

Methods

This is a retrospective cohort study examining the association between GnRHa use and subsequent use of gender-affirming hormones among TGD youth enrolled in the US Military Health System (MHS) between October 2009 and April 2018 and using their TRICARE health plan benefit. TRICARE Prime is the medical health plan benefit for almost 4.8 million people stationed around the world, including active-duty service members in the US Army, Air Force, Marines, and Navy; military retirees; and their families. Data for this study were extracted from the Military Health System Data Repository (MDR) by a member of the research team (A.S.) in 2019. The MDR includes insurance billing records for inpatient care, outpatient care, and outpatient prescriptions that were paid for by TRICARE. This study was approved by the authors' local institutional review boards as a secondary analysis of deidentified, preexisting data. Consent was not needed because the data were deidentified, in accordance with 45 CFR, subpart A, §46.104, exempt research, exception 4. This manuscript was prepared in accordance with the Reporting of Studies Conducted Using Observational Routinely-Collected Health Data (RECORD) statement.

In a previous study,[7] using the same data source as this study, the investigators identified 3754 youth, younger than 18 years, who had at least 1 health care encounter with a transgender-related diagnosis. For this study, we further refined our sample population using the inclusion criteria outlined here. Patients were required to have at least 2 distinct encounters associated with 1 or more of the following codes: *International Classification of Diseases, Ninth Revision* codes 302.6, 302.85, 302.50, 302.51, 302.52, and 302.53; and *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* codes F64.0, F64.1, F64.2, F64.8, and Z87.890. The initial TGD-related visit had to occur between ages 10 and 17 years, and the patient needed to have at least 1 medical encounter, for any reason, occurring after their 14th birthday. On the basis of current guidelines, patients are required to have the cognitive capacity to provide meaningful informed consent or assent to treatments with permanent effects before starting gender-affirming hormones. Some adolescents have developed this level of cognitive capacity as early as age 14 years, and most have developed it by age 16 years.[8] Therefore, age 14 years is generally the earliest a clinician will consider prescribing a patient gender-affirming hormones. Requiring a patient to have at least 1 clinical encounter after turning 14 years old provided all subjects an opportunity to start hormone therapy during our study period.

Pharmacy records were accessed to identify all prescriptions for GnRHa and initial prescriptions for gender-affirming hormones occurring between 30 days before their first clinic visit addressing gender dysphoria and 90 days after their final clinic visit addressing gender dysphoria. Discontinuation of GnRHa treatment was defined as no GnRHa prescriptions for a period 3 times as long as their most recent prescription length. Initiation of gender-affirming hormones was defined as first use of sex hormones inconsistent with their sex assigned at birth. We used sex indicated by the earliest gender marker recorded in the MDR as a proxy for sex assigned at birth. We excluded patients if their first prescription for gender-affirming hormones occurred before or at the same time as starting GnRHa.

Demand for gender-affirming medical care for pediatric age patients increased during our study period. Demand peaked in 2016 when TRICARE officially authorized payment for gender-affirming medical care, on September 1, 2016.[30,31] We created a measure of time by dividing our sample of patients into 3 roughly equal-sized groups according to the date of their initial TGD-related encounter. Our periods included the period of lower demand for gender-affirming care before official approval of payment for gender-affirming care by TRICARE (October 2009 to December 2014), the period of increased demand for gender-affirming care before official authorization of care (January 2015 to August 2016), and the period after insurance approval (September 2016 to April 2018). We

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also collected insurance sponsor's rank (officer vs enlisted) as a proxy for socioeconomic status on the basis of the assumption that an enlisted insurance sponsor would have a lower income than an officer while on active duty, and most officers have a college education whereas many enlisted sponsors do not.[32]

Statistical Analysis

The analysis for this study was completed in August 2022. We used Kaplan-Meier survival analyses to estimate the time from the patient's first encounter for a TGD-related diagnosis to initiation of gender-affirming hormones. We also assessed the association of time to initiation of gender-affirming hormones with GnRHa use and demographic factors. Patients were censored if they reached their final billable clinical encounter in the MHS before the end of the study period. We used the Breslow (generalized Wilcoxon) χ^2 test to assess the bivariate association of demographic factors, TRICARE transgender coverage status (officially approved vs unapproved), and date of initial transgender-related encounter with time to starting hormones. We used bivariable and multivariable Cox proportional hazard analyses to assess the independent association of our variables on the hazard of starting gender-affirming hormones. We used visual inspection of the log-log survival curve to ensure that the proportional hazard assumption was not violated. Our threshold for statistical significance in this study was $P < .05$ for 2-sided tests.

We conducted a subanalysis of the association between GnRHa use and time to initiation of gender-affirming hormones among patients who were aged 10 to 13 years at the time of their initial TGD-related medical encounter. Previous research has suggested that age 10 to 13 years is a key period in the development of gender identity and persistence or desistence of gender dysphoria.[33] Many patients are also experiencing pubertal development during this period and would obtain the most benefit from GnRHa treatment. SPSS statistical software version 28.0.1.0 (IBM) was used for statistical analysis.

Results

We identified 434 TGD youth who met our inclusion criteria: 143 with an initial encounter in October 2009 to December 2014, 133 in January 2015 to August 2016, and 158 in September 2016 to April 2018. Most patients were assigned female at birth (312 patients [71.9%]) and had an enlisted

Table 1. Transgender Individuals Aged 10 to 17 Years Seeking Gender-Affirming Medical Care in the Military Heath System by Year of First Transgender-Related Encounter, 2009-2018

Characteristic	Participants, No. (%)			
	TRICARE did not officially cover gender-affirming medical care		TRICARE officially covered gender-affirming medical care, September 2016 to April 2018 (n = 158)[c]	Total sample, October 2009 to April 2018 (N = 434)
	October 2009 to December 2014 (n = 143)[a]	January 2015 to August 2016 (n = 133)[b]		
Age at first transgender-related encounter, mean (SD), y	15.2 (1.8)	15.4 (1.6)	15.6 (1.2)	15.4 (1.6)
Age group at first transgender-related encounter, y				
10-13	22 (15.4)	22 (16.5)	12 (7.4)	56 (12.9)
14-17	121 (84.6)	111 (83.5)	146 (92.6)	378 (87.1)
Sex assigned at birth				
Male	47 (32.9)	35 (26.3)	40 (25.2)	122 (28.1)
Female	96 (67.1)	98 (73.7)	118 (74.8)	312 (71.9)
Parent enlisted or an officer[d]				
Enlisted	99 (69.2)	93 (69.9)	108 (68.1)	300 (69.1)
Officer	44 (30.8)	40 (30.1)	50 (31.9)	134 (30.9)
Prescribed gonadotropin-releasing hormone analogue	19 (13.3)	27 (20.0)	24 (15.2)	70 (16.1)

[a] There were 20 new patients in October 2009 to December 2010, 15 new patients in 2011, 20 new patients in 2012, 34 new patients in 2013, and 54 new patients in 2014.

[b] There were 92 new patients in 2015 and 41 new patients in 2016.

[c] There were 64 new patients September 2016 to December 2016 and 94 new patients January 2017 to April 2018.

[d] Denotes current rank or rank before retirement from the military.

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insurance sponsor (300 patients [69.1%]). The mean (SD) age at the first TGD-related encounter was 15.4 (1.6) years. The number of patients presenting for gender-affirming medical care increased over time. The mean age at the first TGD-related encounter and the ratio of those assigned male to female did not change over time (**Table 1**).

The median interval between the first TGD-related encounter and starting gender-affirming hormones was 1.1 years (95% CI, 0.9-1.3 years). Within 1 year of the initial TGD-related encounter, an estimated 46.4% of TGD adolescents aged 10 to 17 years (95% CI, 41.7%-51.1%) had started gender-affirming hormones. Within 4 years of the initial encounter, 88.3% of TGD adolescents (95% CI, 84.8%-91.8%) had started gender-affirming hormones.

The median interval between the first TGD-related encounter and starting hormones decreased over time, from 2.3 years (95% CI, 1.7-2.8 years) between October 2009 and December 2014 to 0.6 years (95% CI, 0.5-0.6 years) between September 2016 and April 2018. Hormone use at 18 months after diagnosis increased with recency of first diagnosis date: 36.6% of adolescents (95% CI, 28.8%-44.4%) in October 2009 to December 2014, 65.4% (95% CI, 58.0%-72.8%) in January 2015 to August 2016, and 95.3% (95% CI, 87.3%-100%) in September 2016 to April 2018. TGD youth who

Table 2. Gonadotropin-Releasing Hormone Analogue Use

Demographics	Patients started using a gonadotropin-releasing hormone analogue, No. (%) (N = 434)	
	No (n = 364)	Yes (n = 70)
Sex assigned at birth[a]		
Male	94 (77.0)	28 (23.0)
Female	270 (86.5)	42 (13.5)
Age at first transgender diagnosis, y[a]		
10-13	24 (42.9)	32 (57.1)
14-17	340 (88.9)	38 (10.1)
Insurance sponsor rank		
Enlisted	251 (83.7)	49 (16.3)
Officer	113 (84.3)	21 (15.7)

[a] Differences between groups were statistically significant at $P < .05$.

Table 3. Association of Patient Factors With Initiation of Gender-Affirming Hormones

Factor	Time from initial encounter to initiation of gender-affirming hormones (KM estimate), median (95% CI), y	HR (95% CI)[a]	
		Hazard of starting hormones (bivariable analyses)	Independent hazard of starting hormones (multivariable analyses)
Total sample	1.1 (0.9-1.3)	NA	NA
Date of initial diagnosis			
October 2009 to December 2014	2.3 (1.7-2.8)	1 [Reference]	1 [Reference]
January 2015 to August 2016	1.1 (0.9-1.3)	2.25 (1.71-2.97)	2.43 (1.84-3.21)
September 2016 to April 2018[b]	0.6 (0.5-0.6)	4.92 (3.59-6.74)	5.12 (3.72-7.04)
Prescribed gonadotropin-releasing hormone analogue			
No	1.0 (0.8-1.2)	1 [Reference]	1 [Reference]
Yes	1.8 (1.1-2.4)	0.52 (0.37-0.71)	0.54 (0.38-0.77)
Age at initial diagnosis, y			
10-13	2.1 (1.5-2.8)	1 [Reference]	1 [Reference]
14-17	1.0 (0.9-1.2)	2.03 (1.46-2.84)	1.42 (0.98-2.07
Sponsor's rank[c]			
Enlisted	1.1 (0.9-1.3)	1 [Reference]	NA[d]
Officer	1.0 (0.7-1.3)	1.06 (0.85-1.33)	
Sex assigned at birth			
Male	1.3 (1.0-1.5)	1 [Reference]	NA[d]
Female	1.1 (0.9-1.2)	1.25 (0.99-1.58)	

Abbreviations: HR, hazard ratio; KM, Kaplan-Meier; NA, not applicable.

[a] HRs and 95% CIs were determined by Cox proportional hazards analyses.

[b] On September 1, 2016, TRICARE adjusted the list of covered conditions to include gender-affirming medical rendered to military retirees and family members of active duty and retired service members.

[c] Enlisted service members are required to complete high school, whereas officers are required to complete college before joining the US military. Officers also have higher pay while in the military and military pension after retirement. We are using this factor as a proxy for family income.

[d] Not included in multivariable model.

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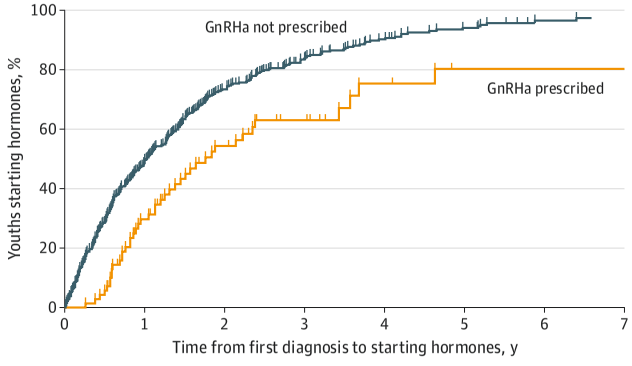
were initially seen after September 2016 had an almost 5 times higher hazard of starting gender-affirming hormones (hazard ratio, 4.92; 95% CI, 3.59-6.74) than patients who had an initial transgender-related encounter between 2009 and 2014.

Patients who were 10 to 13 years old at the initial TGD-related encounter were more likely than patients who were 14 to 17 years old to be prescribed GnRHa (32 patients [57.1%] vs 38 patients [10.1%]) and had a larger interval between the initial TGD-related appointment and starting gender-affirming hormones (**Tables 2** and **3**). Compared with patients without GnRHa use, GnRHa use was associated with a longer median gap between the initial appointment and starting gender-affirming hormones (1.8 years [95% CI, 1.1-2.4 years] vs 1.0 years [95% CI, 0.8-1.2 years]) and a lower hazard of starting gender-affirming hormones (hazard ratio, 0.52; 95% CI, 0.37-0.71) (**Figure 1**). This association was consistent across time periods. We saw this same association when we restricted our analyses to 54 patients who were aged 10 to 13 years at the time of their first TGD-related encounter (**Figure 2**). Most patients (63 of 70 patients [90%]) who started GnRHa continued treatment until they started gender-affirming hormones or were censored from further analysis. Of the 7 patients in our study who started and then stopped GnRHa treatment while continuing to seek medical care using their TRICARE benefit, 3 went on to start testosterone.

GnRHa use was more common among patients who were assigned male at birth than those who were assigned female (28 patients [23.0%] vs 42 patients [13.5%]) but GAH use was not (Table 3).

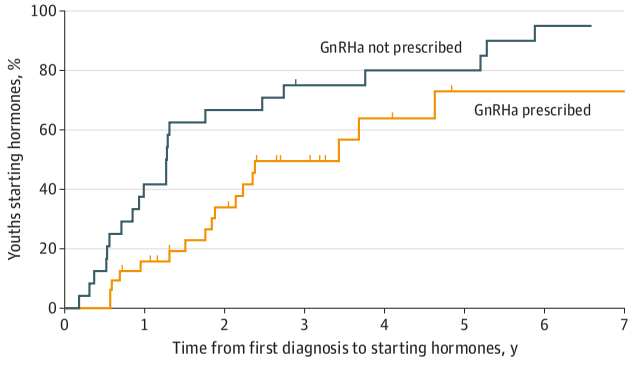
Figure 1. Use of Gonadotropin-Releasing Hormone Analogues (GnRHa) and Gender-Affirming Hormones Among Transgender Youth Aged 10 to 17 Years



No. at risk

GnRHa not prescribed	364	83	23	4
GnRHa prescribed	70	24	6	3

Figure 2. Use of Gonadotropin-Releasing Hormone Analogues (GnRHa) and Gender-Affirming Hormones Among Transgender Youth Aged 10 to 13 Years



No. at risk

GnRHa not prescribed	23	8	4	1
GnRHa prescribed	31	18	6	2

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Sponsor's military rank (a proxy for socioeconomic status) was not associated with initiation of GnRHa or gender-affirming hormones (Table 3). In multivariable analysis including GnRHa use, time of the initial transgender-related encounter, and patient age at the time of the first encounter, only GnRHa use and time of the initial encounter had an independent association with the hazard of initiating gender-affirming hormones.

Discussion

The findings of this cohort study suggest that GnRHa treatment is not associated with increased progression to gender-affirming hormones among treatment-seeking TGD adolescents in a population receiving low or no-cost medical care in the MHS. We also found that number of patients per year presenting for gender-affirming medical care increased during our study period, whereas the time between the initial TGD-related encounter and initiation of gender-affirming hormones decreased, but the median age at presentation remained the same. Patients who were older at the time of the initial TGD-related encounter had a shorter median time between the first medical encounter and initiation of gender-affirming hormones and were more likely to start gender-affirming hormones in general. We also found that assigned male patients were significantly more likely than assigned female patients to start GnRHa, but not gender-affirming hormones. In a medical system with low or no-cost medical care, the sponsor's military rank (a proxy for socioeconomic status) was not associated with differences in use of gender-affirming hormones by TGD adolescents.

Across the MHS, we saw lower rates of progression from GnRHa treatment to gender-affirming hormones among TGD adolescents than were seen in studies of specialized gender clinics in Europe (92%-98%).[4,20,23] Some of the national centers in Europe examined in prior studies had more stringent criteria for initiation of gender-affirming treatment than patients seen in the MHS, such as requiring patients to have at least 6 months of involvement with child psychology or psychiatry before starting GnRHa treatment,[4,21] requiring patients to have persistent gender dysphoria since childhood that increased with puberty,[13,17,21] or requiring patients to start GnRHa treatment before obtaining access to gender-affirming hormones.[23] These additional criteria may influence patterns of GnRHa use and account for some of the difference observed in progression from GnRHa use to gender-affirming hormone use. We also included younger children in our study compared with previous studies, and clinicians in the MHS initiated GnRHa at younger ages than in previous studies.[4,5] In our study, younger patients were less likely to initiate gender-affirming hormones; therefore, inclusion of these patients might also account for the lower rate of gender-affirming hormone use seen in our study. This lower rate of starting gender-affirming hormone therapy among younger patients is consistent with previous studies finding that age 10 to 13 years is a key period for confirmation of gender identity and determining whether gender dysphoria will persist or resolve.[33] TGD patients first presenting at an older age may have passed through this period of identity consolidation and are more likely to have persistent gender dysphoria. However, consistent with other studies, few TGD patients discontinued treatment.

Use of GnRHa treatment in younger adolescents is reversible and associated with improvements in mental health and cosmetic outcomes if gender dysphoria persists.[8,9,12-18] In our study, we found that use of GnRHa treatment among adolescents did not collectively increase future use of gender-affirming hormones. This suggests that clinicians can offer GnRHa treatment to young TGD adolescents without an increased likelihood of future use of gender-affirming hormones.

Limitations

This study has limitations that should be addressed. It is a retrospective cohort analysis of administrative data from patients enrolled in the US military health plan program, TRICARE. The children of active duty or retired service members identified in our study are different from the general population in several ways. Compared with the general population in the US, children of active duty and retired service members have families with a higher average socioeconomic standing,

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higher levels of parental education, medical care coverage with lower out-of-pocket expenses and more comprehensive health care coverage, and higher geographic mobility. These factors limit the generalizability of our findings. As this is a study of health plan administrative data, we do not have information on care obtained by the family without using their TRICARE benefit. In the US, medical expenses can be covered by employer-funded private medical insurance, government insurance programs for the economically disadvantaged and elderly adults, individually purchased private insurance obtained with or without cost subsidies from the government, and paying out of pocket at the time of service. Individuals can have multiple types of insurance at the same time, such as a military retiree with TRICARE and commercial insurance through their employer, and can select which program they use to pay for health care services. It is possible that patients elected to obtain gender-affirming medications without using their TRICARE benefit, while still obtaining other medical care in the MHS. However, the difference in cost between commercial insurance programs and TRICARE make this less likely. The average out-of-pocket medication costs would be $500 per year using commercial insurance vs $0 to $36 per year using TRICARE for a transgender woman and $230 per year vs $0 to $72 per year for a transgender man.[34] We also did not capture information on individual patient, parent, and clinician factors that may influence decisions about starting or stopping gender-affirming medical treatments, or to seek out these treatments at all. Future studies examining the individual patient, family, clinician, and governmental factors influencing initiation and discontinuation of gender-affirming medications, conducted with more generalizable samples, would be helpful to clinicians when counseling patients and families on the risks and benefits of gender-affirming medications and monitoring treatment.

Conclusions

In this cohort study of transgender adolescents, GnRHa use was not associated with an increased hazard of subsequent gender-affirming hormone use. These data suggest that clinicians can offer the benefits of GnRHa treatment to TGD youth with gender dysphoria without concern for unduly or inappropriately increasing rates of subsequent gender-affirming hormone use.

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Corresponding Author: Christina Marie Roberts, MD, MPH, Division of Adolescent Medicine, Children's Mercy Kansas City, 3101 Broadway Blvd, 10th Floor, Kansas City, MO 64111 (taroberts@cmh.edu).

Author Affiliations: Division of Adolescent Medicine, Children's Mercy Kansas City, Kansas City, Missouri (Nos, Roberts); Department of Pediatrics, University of Missouri-Kansas City School of Medicine, Kansas City (Nos, Roberts); Department of Family Medicine, Uniformed Services University, Bethesda, Maryland (Klein); Department of Pediatrics, Uniformed Services University, Bethesda, Maryland (Klein, Hisle-Gorman, Susi); Department of Family Medicine, David Grant Medical Center, Travis Air Force Base, California (Klein); Department of Preventive Medicine and Biostatistics, Uniformed Services University, Bethesda, Maryland (Adirim); Department of Medical and Clinical Psychology, Uniformed Services University, Bethesda, Maryland (Schvey); Department of Preventive Medicine and Biostatistics, Uniformed Services University, Bethesda, Maryland (Hisle-Gorman).

Author Contributions: Dr Roberts had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Nos, Klein, Adirim, Schvey, Hisle-Gorman, Roberts.

Acquisition, analysis, or interpretation of data: Nos, Klein, Schvey, Hisle-Gorman, Susi, Roberts.

Drafting of the manuscript: Nos, Klein, Roberts.

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Critical revision of the manuscript for important intellectual content: Nos, Klein, Adirim, Schvey, Hisle-Gorman, Susi.

Statistical analysis: Roberts.

Administrative, technical, or material support: Hisle-Gorman, Susi, Roberts.

Supervision: Klein, Adirim, Roberts.

Conflict of Interest Disclosures: Dr Roberts reported receiving grants from Organon Pharmaceuticals for a study of contraception use among US servicewomen, personal fees from Organon Pharmaceuticals for participation in a focus group discussing contraception use among adolescents, and grants from Uniformed Service University of the Health Sciences to study contraceptive use and reproductive health outcomes among young enlisted servicewomen in the US military outside the submitted work. No other disclosures were reported.

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Role of the Funder/Sponsor: The funder had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Disclaimer: The contents of this article are solely the responsibility of the authors and do not necessarily represent the official views of the Uniformed Services University, the US Air Force, the US Navy, the US Department of Defense, or the US government.

Meeting Presentation: This research was presented in a poster symposium at the 2022 Society for Adolescent Health and Medicine annual meeting; March 9, 2022; virtual.

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Subject: Re: your quotes for the NEJM release

Hi [redacted] and [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Talk to you mañana,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 3:48 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Yes, will send over a Zoom invite-- let's go for 3:45pm. Thanks!
[redacted]

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 3:01 PM
To: [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

[redacted]

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Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 10:12 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Yes, that works for me.

Thanks

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 9:58 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

I'm main speaker at a conference in Calgary until 1:30 pm, so 12:30 won't work. I'm free from 3 pm to 5:30 pm, if anything in that time period works for the two of you.

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 9:18 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Works for me.

Thanks,

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Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 9:18 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Sounds good. Could 12:30pm work for you both?

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 17, 2022 9:16 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>
Subject: Re: your quotes for the NEJM release

Hi [redacted]

I'm happy to do a 5 minute call/zoom with you and [redacted]. Any time tomorrow (Friday) from noon or later would work for me.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 8:19 AM
To: [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: your quotes for the NEJM release

Hi again, Lurie is happy to have both of you contribute quotes to the release for the NEJM piece. Would you be able to get those to me by the Monday after Thanksgiving at latest? If easiest, we could also have a five-min call where you tell me what you'd generally like to say, and I can shape it into a quote (some folks find that process easier)-- whatever you prefer!
Thanks, [redacted]

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@luriechildrens.org>
Sent: Friday, November 18, 2022 8:47 AM PST
To: [redacted]@chla.usc.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@childrens.harvard.edu>; [redacted]@luriechildrens.org>
Subject: FW: FOLLOW UP FOR REPLY Re: reporter on deadline for The BMJ

This Message Is From an External Sender
This message came from outside your organization.

Colleagues beware..., This has nut-job written all over it

From: Jennifer Block <jblock@bmj.com>
Sent: Friday, November 18, 2022 9:39 AM
To: [redacted]@luriechildrens.org>
Cc: [redacted]@northwestern.edu>; [redacted]@luriechildrens.org>
Subject: FOLLOW UP FOR REPLY Re: reporter on deadline for The BMJ

Hi [redacted],

My piece on gender medicine is coming out soon in The BMJ and I wanted to give you the opportunity to respond to works you've authored and statements you've made publicly that are discussed in the article.

1.) You are a principal investigator of the NIH study on the impacts of early medical treatment in transgender youth, which promised to "provide essential evidence-based data on the physiological and psychosocial effects and safety" of current treatments. This study is following two groups, one of subjects who began receiving GnRHa in early puberty and another who began sex hormone treatment in adolescence. Why is there no concurrent, no-treatment control group? When will the key outcomes be published?

2) On a recent podcast titled "Evidence-Based Gender-Affirming Care for Young Adults," you said the evidence base remains "a challenge … it is a discipline where the evidence base is now being assembled." You also said that "it's truly lagging behind" clinical practice and that "only now, I think, are we really beginning to do the type of research where we're looking at short, medium and long-term outcomes of the care that we are providing in a way that I think hopefully will be either reassuring to institutions and families and patients or also will shed a light on things that we can be doing better." Without high quality evidence of safety and efficacy, what is the basis for claims that gender-affirming care is both "evidence based" and "being done safely"?

3) You are credited as "contributor" of the AAP 2018 policy statement "Ensuring Comprehensive Care and Support for Transgender and Gender Diverse Children and Adolescents." Can you explain what your role was as a contributor and how it differed from named authors? Roughly what year/month did your role as contributor begin? Were you compensated for this role?

4) The AAP statement recommends that children and adolescents "have access to comprehensive, gender-affirming, and developmentally appropriate health care," including puberty blockers, sex hormones, and surgery. Since this statement was published, entities in Finland, Sweden, and England have issued guidelines that restrict these treatments outside of research settings. Sweden determined earlier this year that the risks of puberty suppression and treatment with hormones "currently outweigh the possible benefits" for minors. Given these findings and the limitations you acknowledge regarding the evidence base, what was the rationale for this policy statement? Will you be contributing again to its 2023 revision?

5) On the podcast, you said "There is universal support for gender-affirming care from every mainstream U.S. based medical society that I can think of: the AMA, the APA, the AAP. I mean, these organizations never agree with one another..." How do you interpret these endorsements vis a vis the evidence and the findings of medical entities outside the U.S.?

6) I've spoken to several U.S. clinicians who are concerned that minors are being "fast-tracked" to treatments that will have lifelong impacts and they point to the AAP statement as having contributed to the growth of clinics that are not performing careful mental health assessments prior to initiating GnRH or sex hormone treatment--that some have taken the term "gender affirming" to mean "go ahead and do anything that affirms," and that the policy furthered the notion that psychotherapeutic gender exploration is equivalent to "conversion therapy," which is prohibited. What was the desired outcome for the AAP policy statement?

7) The AAP statement refers to GnRHa treatment as "reversible." Given that 96-98% of children whose puberty is suppressed go on to take sex hormones, and that there are known and unknown long term impacts on sexual development, cognitive development, bone development, and fertility, can you clarify what was meant by "reversible", and whether you agree with the AAP on this point today? Additionally, the AAP statement does not mention potential impacts on sexual function and maturation--were these factors considered prior to the AAP statement?

Thank you. If you can respond by Monday, November 21, we'd appreciate it.

Jennifer

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

On Tue, 25 Oct 2022 at 14:20, Jennifer Block <jblock@bmj.com> wrote:

> OK thanks, do let me know. At BMJ we are focused on medical evidence and practice, not politics.
>
> Thanks,
> Jennifer
>
> On Mon, 24 Oct 2022 at 14:05, [redacted]@luriechildrens.org> wrote:
>
> > In part related to the overall climate these days, I do not think we are granting interviews right now.
> >
> > But I am cc'ing [redacted] our media contact.
> >
> > [redacted]
> >
> > Get Outlook for iOS
> >
> > **From:** Jennifer Block <jblock@bmj.com>
> > **Sent:** Monday, October 24, 2022 12:35:18 PM
> > **To:** [redacted]@northwestern.edu>
> > **Subject:** reporter on deadline for The BMJ
> >
> > Hello [redacted],
> >
> > I'm a reporter with The BMJ working on a story about medical care for transgender youth and have run across your name in several publications. I'm interested in speaking with you about the evolution of the affirmative care model as well as the evidence base.
> >
> > Can we talk this week at your earliest convenience? I'm generally available 11-5 CT.
> >
> > Thank you,
> > Jennifer
> > 917-848-0205
>
> BMJ is a healthcare knowledge provider with a vision for a healthier world. We share knowledge and expertise to improve healthcare outcomes. See how we are making a difference in our latest impact report:
> https://www.bmj.com/company/impact-report/ This email and any attachments are confidential. If you have received this email in error, please delete it and kindly notify us. If the email contains personal views then BMJ accepts no responsibility for these statements. The recipient should check this email and attachments for viruses because the BMJ accepts no liability for any damage caused by viruses. Emails sent or received by BMJ may be monitored for size, traffic, distribution and content. BMJ Publishing Group Limited trading as BMJ. A private limited company, registered in England and Wales under registration number 03102371. Registered office: BMA House, Tavistock Square, London WC1H 9JR, UK.

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Obtained via CPRA by Judicial Watch, Inc.

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, November 18, 2022 3:39 PM PST
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
CC: [redacted] <[redacted]@ucsf.edu>
Subject: Please review: Stewardship report for [redacted]
Attachment(s): "Pritzker.GenderCenter.11.18.22.docx"

Hello [redacted] and Stephen,
I hope you both are doing well. I have thoroughly enjoyed getting to know you both in our interview and then writing this report (with help from*your* report)! I am so very grateful to you both for doing this work.

Attached is the report to Mr. [redacted]. I wrote through your report and added details from our interview -- there is one question to answer.

If you could please review the draft for accuracy and send it back to me by Monday, Nov. 28 we could send it out in November. Please let me know if you have any questions.

Thanks again for your time and your amazing work.
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, October 18, 2022 4:13 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: Re: Interview Friday, 10.21.22? Re: Introductions - Stewardship report for [redacted]

I'm available 1 pm or 3 pm.

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, October 18, 2022 2:59 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: Interview Friday, 10.21.22? Re: Introductions - Stewardship report for [redacted]

Hello again,
Forgive the gentle nudge. But I am hoping to schedule this interview for Friday, and I wanted to reach out again to you, Dr. [redacted], to see if you are available at 1 pm, 2 pm or 3 pm on Friday, Oct. 21?

As I understand it from [redacted], these are the points we want to cover in the report:

- Established new position Director of Advocacy and recruited highly sought-after candidate
- Moving into the Pritzker building
- Hiring new position: Director of Education
- Strengthened community partnership with Mind the Gap (providers with gender affirming approach who accept referrals form UCSF)
- Hired [redacted], RN, who is fluent in Cantonese and English.

Crossing my fingers that Friday afternoon will work for you, Dr. [redacted].
Thanks so much,
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 14, 2022 1:54 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: Re: Introductions - Stewardship report for [redacted]

Hello Steve,
Thanks so much for your prompt reply !I can meet at 1 pm, 2 pm or 3 pm on Friday, Oct. 21.

[redacted], I am hoping one of those times works for you. Once we have confirmed, I will send a zoom invite.

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Best,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 14, 2022 1:50 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Introductions - Stewardship report for [redacted]

Hi [redacted],

Nice to meet you! I would be happy to be present with [redacted] for the entire interview. I believe Friday afternoons are best for [redacted], and I'm available starting at 1 PM on 10/21 (pending one potential conflict).

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 14, 2022 12:29 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Introductions - Stewardship report for [redacted]

Hello Dr. Rosenthal and Dr. [redacted],

Thanks, [redacted], for your introduction. I write stewardship reports for UCSF, and I am eager to talk to you both about this gift. It can be difficult to interview two people at the same time -- so if I can focus on one person for one part of the story and the other person for the other part of the story, that might be the most efficient way to handle this. And if you would both like to be present for the entire interview -- that's fine.

If you could send me times and days that you are both available during the next week -- that would be greatI would like to handle this interview before Oct. 25 because I will be gone for a week starting Oct. 26. I hope that doesn't make this too inconvenient.

I look forward to hearing from you.
Thanks so much,
[redacted]

[redacted]
Senior Donor Relations Writer, Advanced Communications
University Development & Alumni Relations

University of California, San Francisco
2001 The Embarcadero, 3rd Floor | Box 0248
San Francisco, CA 94143
mobile: [redacted]
[redacted]@ucsf.edu

UCSF

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 14, 2022 12:11 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: Introductions - Stewardship report for [redacted]

Good morning Steve and [redacted],

I'd like to introduce you to my esteemed colleague [redacted] who is drafting a stewardship report for [redacted]. You might recall Mr. [redacted] gave last year per [redacted]'s request.

[redacted] would like to speak with you about the highlights that should be included. I suggested:

- Established new position Director of Advocacy and recruited highly sought-after candidate
- Moving into the Pritzker building
- Hiring for a new position Director of Education
- Strengthened community partnership with Mind the Gap
- Hired [redacted], RN, who is fluent in Cantonese and English.

I will not be part of the meeting with you and [redacted], so I will defer to her on scheduling.

Best,
[redacted]

UCSF Benioff Children's Hospitals

[redacted]
Director of Development,
Children's Health
Pronouns: *she, her, hers*

C [redacted]
E [redacted]@ucsf.edu

UCSF Benioff Children's Hospitals Foundation

give.ucsfbenioffchildrens.org

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted] <[redacted]@gmail.com>
Sent: Sunday, November 20, 2022 9:46 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Couple of things

This Message Is From an External Sender
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Hey Steve,
Thank you for your article! I think it's a great update and very accessible for the lay public to read.

And I really appreciate your tips on Loreto! We're going to do some more research on going there. If you recall, did you like the place you stayed?
Was there anything you would have made sure to do/or not do if you went back?
I think we're hoping for the whale watching and some snorkeling if it's not too cold.

I hope you have an enjoyable Thanksgiving.
[redacted]

[redacted], Ph.D.
Co-Chair/Mental Health Chair, WPATH GEI
Past President, Georgia Psychological Association
Adjunct Assistant Professor, Dept. of Psychiatry & Behavioral Sciences,
Emory University School of Medicine
Licensed Psychologist
(He, him, his)

[redacted]

On Thu, Nov 17, 2022 at 1:12 PM Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu> wrote:

> Hi [redacted],
>
> Nice to hear from you, and great that we were able to be together in person in Montreal!
>
> Very exciting that you may go to Loreto in Feb/March '23! I hope it works out! The Blue whales could be seen just off the coast Loreto. The gray whales were seen (and touched!) on the Pacific side of Baja—southwest of Loreto (near San Carlos, as I recall).
>
> I have attached a more recent (2021) review I did for Nature Reviews Endocrinology that has an updated section on "Biological factors in gender identity".
>
> I hope you have a wonderful Thanksgiving, and yes, it would be great to see each other in another in- person GEI!
>
> Best wishes,
>
> Steve
>
> Stephen M. Rosenthal, M.D.
> Professor of Pediatrics
> Division of Pediatric Endocrinology
> Medical Director, Child and Adolescent Gender Center
> University of California, San Francisco
> Mission Hall: Global Health and Clinical Sciences
> 550 16th St., 4th Floor, #4635
> San Francisco CA 94143-0434
> Pronouns: he/him/his
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> Director, World Professional Association for Transgender Health
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> Tel.: (415) 476-2266
> Fax: (415) 476-5356
> email: Stephen.Rosenthal@ucsf.edu
>
> ---
>
> **From:** [redacted] <[redacted]@gmail.com>
> **Sent:** Thursday, November 17, 2022 4:12 AM
> **To:** Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
> **Subject:** Couple of things

Obtained via CPRA by Judicial Watch, Inc.

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Hey Steve,
I hope you're doing well. It was really good to see you and talk with you in Montreal!

I wanted to thank you for telling me about your wonderful whale-watching experience in Loreto. We have put it on our travel list, and we may even get out there this February/March 2023! We both love animals and nature, so this looks like a great encounter with both!

On a work related note, I have often cited your 2014 review article in JCEM about biological factors in gender identity. I was wondering if you have done or seen a more recent one that you like that you would share with me.

Hopefully we will see each other sometime in the near future with another in person GEI!
[redacted]

[redacted], Ph.D.
Co-Chair/Mental Health Chair, WPATH GEI
Past President, Georgia Psychological Association
Adjunct Assistant Professor, Dept. of Psychiatry & Behavioral Sciences,
Emory University School of Medicine
Licensed Psychologist
(He, him, his)

[redacted]

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@chla.usc.edu>
Sent: Monday, November 21, 2022 12:31 PM PST
To: [redacted]@luriechildrens.org>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@childrens.harvard.edu>; [redacted]@luriechildrens.org>
Subject: RE: FOLLOW UP FOR REPLY Re: reporter on deadline for The BMJ

This Message Is From an External Sender
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This is definitely an avoid at all costs

From: [redacted]@luriechildrens.org>
Sent: Friday, November 18, 2022 8:48 AM
To: [redacted]@chla.usc.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@childrens.harvard.edu>; [redacted]@luriechildrens.org>
Subject: FW: FOLLOW UP FOR REPLY Re: reporter on deadline for The BMJ (EXTERNAL EMAIL)

CAUTION: BE CAREFUL WITH THIS MESSAGE
This email came from outside CHLA. Do not open attachments, click on links, or respond unless you recognize the message and recognize the email address. [redacted]

Colleagues beware…, This has nut-job written all over it

From: Jennifer Block <jblock@bmj.com>
Sent: Friday, November 18, 2022 9:39 AM
To: [redacted]@luriechildrens.org>
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Hi [redacted],

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1.) You are a principal investigator of the NIH study on the impacts of early medical treatment in transgender youth, which promised to "provide essential evidence-based data on the physiological and psychosocial effects and safety" of current treatments. This study is following two groups, one of subjects who began receiving GnRHa in early puberty and another who began sex hormone treatment in adolescence. Why is there no concurrent, no-treatment control group? When will the key outcomes be published?

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3) You are credited as "contributor" of the AAP 2018 policy statement "Ensuring Comprehensive Care and Support for Transgender and Gender Diverse Children and Adolescents." Can you explain what your role was as a contributor and how it differed from named authors? Roughly what year/month did your role as contributor begin? Were you compensated for this role?

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7) The AAP statement refers to GnRHa treatment as "reversible." Given that 96-98% of children whose puberty is suppressed go on to take sex hormones, and that there are known and unknown long term impacts on sexual development, cognitive development, bone development, and fertility, can you clarify what was meant by "reversible", and whether you agree with the AAP on this point today? Additionally, the AAP statement does not mention potential impacts on sexual function and maturation--were these factors considered prior to the AAP statement?

Thank you. If you can respond by Monday, November 21, we'd appreciate it.

Jennifer
917-848-0205

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> Thanks,
> Jennifer
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>
> > In part related to the overall climate these days, I do not think we are granting interviews right now.
> >
> > But I am cc'ing [redacted] our media contact.
> >
> > [redacted]
> >
> > Get Outlook for iOS
> >
> > **From:** Jennifer Block <jblock@bmj.com>
> > **Sent:** Monday, October 24, 2022 12:35:18 PM
> > **To:** [redacted]@northwestern.edu>
> > **Subject:** reporter on deadline for The BMJ
> >
> > Hello [redacted]
> >
> > I'm a reporter with The BMJ working on a story about medical care for transgender youth and have run across your name in several publications. I'm interested in speaking with you about the evolution of the affirmative care model as well as the evidence base.
> >
> > Can we talk this week at your earliest convenience? I'm generally available 11-5 CT.
> >
> > Thank you,
> > Jennifer
> > 917-848-0205

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, November 22, 2022 3:44 PM PST
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
CC: [redacted]@ucsf.edu>
Subject: Re: Please review: Stewardship report for [redacted]
Attachment(s): "Pritzker.GenderCenter.11.18.22 D.E. edits.docx"

This is terrific. Attached, my edits. See what you think.

Best,
[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, November 18, 2022 3:39 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Please review: Stewardship report for [redacted]

Hello [redacted] and Stephen,
I hope you both are doing well. I have thoroughly enjoyed getting to know you both in our interview and then writing this report (with help from*your* report)! I am so very grateful to you both for doing this work.

Attached is the report to Mr. [redacted]. I wrote through your report and added details from our interview -- there is one question to answer.

If you could please review the draft for accuracy and send it back to me by Monday, Nov. 28 we could send it out in November. Please let me know if you have any questions.

Thanks again for your time and your amazing work.
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, October 18, 2022 4:13 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: Interview Friday, 10.21.22? Re: Introductions - Stewardship report for [redacted]

I'm available 1 pm or 3 pm.

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e-mail: [redacted]@ucsf.edu

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Sent: Tuesday, October 18, 2022 2:59 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
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Subject: Interview Friday, 10.21.22? Re: Introductions - Stewardship report for [redacted]

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As I understand it from [redacted], these are the points we want to cover in the report:

- Established new position Director of Advocacy and recruited highly sought-after candidate
- Moving into the Pritzker building
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Subject: Re: Introductions - Stewardship report for [redacted]

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Best,
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To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Introductions - Stewardship report for [redacted]

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Thanks,

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Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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Sent: Friday, October 14, 2022 12:29 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Introductions - Stewardship report for [redacted]

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If you could send me times and days that you are both available during the next week -- that would be greatI would like to handle this interview before Oct. 25 because I will be gone for a week starting Oct. 26. I hope that doesn't make this too

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inconvenient.

I look forward to hearing from you.
Thanks so much,
[redacted]

[redacted]
Senior Donor Relations Writer, Advanced Communications
University Development & Alumni Relations

University of California, San Francisco
2001 The Embarcadero, 3rd Floor | Box 0248
San Francisco, CA 94143
mobile: [redacted]
[redacted]@ucsf.edu

UCSF

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To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: Introductions - Stewardship report for [redacted]

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UCSF Benioff Children's Hospitals

[redacted]
Director of Development,
Children's Health
Pronouns: *she, her, hers*

C [redacted]
E [redacted]@ucsf.edu

UCSF Benioff Children's Hospitals Foundation

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Sent: Tuesday, November 22, 2022 3:49 PM PST
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
CC: [redacted]@ucsf.edu>
Subject: Re: Please review: Stewardship report for [redacted]

I am so very glad to hear you are pleased, [redacted]! And I will incorporate your edits.

Steve, have you had a chance to review? Oh, I see your OOO is on. I will wait to hear back from you.

Thank you so much and I hope everyone has a lovely Thanksgiving!
[redacted]

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Subject: Re: Introductions - Stewardship report for [redacted]

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To: [redacted], [redacted] <[redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>
Subject: Re: Introductions - Stewardship report for [redacted]

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Medical Director, Child and Adolescent Gender Center
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550 16th St., 4th Floor, #4635
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Pronouns: he/him/his

Director, World Professional Association for Transgender Health
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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Subject: Re: Introductions - Stewardship report for [redacted]

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I look forward to hearing from you.
Thanks so much,
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[redacted]
Senior Donor Relations Writer, Advanced Communications
University Development & Alumni Relations

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2001 The Embarcadero, 3rd Floor | Box 0248
San Francisco, CA 94143
mobile: [redacted]
[redacted]@ucsf.edu

UCSF

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Cc: [redacted] <[redacted]@ucsf.edu>
Subject: Introductions - Stewardship report for [redacted]

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I will not be part of the meeting with you and [redacted], so I will defer to her on scheduling.

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Director of Development,
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C ([redacted]) [redacted]
E [redacted]@ucsf.edu

UCSF Benioff Children's Hospitals Foundation

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 22, 2022 5:49 PM PST
To: [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Subject: Re: Clinical competency evaluations

Hi [redacted],

I have completed my evaluations for [redacted], the only fellows I've worked with this academic year.

Best wishes,

Steve

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Tel.: (415) 476-2266
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email: Stephen.Rosenthal@ucsf.edu

From: [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Sent: Tuesday, November 22, 2022 2:24 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Clinical competency evaluations

Hi Steve,
I would say that any feedback (especially written comments) can be valuable. Thanks for considering.
Best,
[redacted]

[redacted], M.D.
Associate Clinical Professor of Pediatrics, Division of Endocrinology
Program Director, Pediatric Endocrinology Fellowship Training Program
UCSF Diabetes Center
UCSF School of Medicine
Director of Clinical and Translational Medicine
Immune Tolerance Network
www.ucsf.edu
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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 22, 2022 2:16 PM
To: [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Subject: Re: Clinical competency evaluations

Hi [redacted],
For the current academic year, I've worked with both of the first year fellows only 2 times each. Is that enough to write an evaluation?
Thanks, and I hope you're doing well!
Happy Thanksgiving,
Steve

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To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
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Subject: Clinical competency evaluations

Hi everyone,
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Thanks very much for your help.

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Thank you, Steve! I appreciate you filling those out. Have a great Thanksgiving!

[redacted], M.D.
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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 22, 2022 5:51 PM PST
To: [redacted]@ucsf.edu>
Subject: Re: Clinical competency evaluations

You're welcome, [redacted], and Happy Thanksgiving to you and your family!

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 22, 2022 5:50 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Clinical competency evaluations

Thank you, Steve! I appreciate you filling those out. Have a great Thanksgiving!

[redacted], M.D.
Associate Clinical Professor of Pediatrics, Division of Endocrinology
Program Director, Pediatric Endocrinology Fellowship Training Program
UCSF Diabetes Center
UCSF School of Medicine
Director of Clinical and Translational Medicine
Immune Tolerance Network
www.ucsf.edu
www.immunetolerance.org

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 22, 2022 5:49 PM
To: [redacted]@ucsf.edu>
Subject: Re: Clinical competency evaluations

Hi [redacted]

I have completed my evaluations for [redacted] the only fellows I've worked with this academic year.

Best wishes,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
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Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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From: [redacted]@ucsf.edu>
Sent: Tuesday, November 22, 2022 2:24 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Clinical competency evaluations

Hi Steve,
I would say that any feedback (especially written comments) can be valuable. Thanks for considering.
Best,
[redacted]

[redacted], M.D.
Associate Clinical Professor of Pediatrics, Division of Endocrinology
Program Director, Pediatric Endocrinology Fellowship Training Program
UCSF Diabetes Center
UCSF School of Medicine
Director of Clinical and Translational Medicine
Immune Tolerance Network
www.ucsf.edu
www.immunetolerance.org

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 22, 2022 2:16 PM
To: [redacted]@ucsf.edu>
Subject: Re: Clinical competency evaluations

Hi [redacted],
For the current academic year, I've worked with both of the first year fellows only 2 times each. Is that enough to write an evaluation?
Thanks, and I hope you're doing well!
Happy Thanksgiving,
Steve

Get Outlook for iOS

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 22, 2022 2:35:11 PM
To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Clinical competency evaluations

Hi everyone,
I wanted to reach out to you all to ask that you complete the clinical competency evaluation requests waiting for you in Med Hub (UCSF - MedHub)by the end of today. These evaluations are incredibly important to the overall fellow evaluation process.

Thanks very much for your help.

[redacted]

[redacted] M.D.
Associate Clinical Professor of Pediatrics, Division of Endocrinology
Program Director, Pediatric Endocrinology Fellowship Training Program
UCSF Diabetes Center
UCSF School of Medicine
Director of Clinical and Translational Medicine
Immune Tolerance Network
www.ucsf.edu
www.immunetolerance.org

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 22, 2022 6:17 PM PST
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>
Subject: Re: Please review: Stewardship report for [redacted]
Attachment(s): "Pritzker.GenderCenter.11.18.22 D.E._SMR_ edits.docx"

Dear [redacted],

I agree with [redacted]—this is terrific! I really appreciate all the thought and care that went into it!
i have made a few small edits on the attached.

Thanks, and Happy Thanksgiving!

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
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Director, World Professional Association for Transgender Health
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Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 22, 2022 3:49 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: Please review: Stewardship report for [redacted]

I am so very glad to hear you are pleased, [redacted]! And I will incorporate your edits.

Steve, have you had a chance to review? Oh, I see your OOO is on. I will wait to hear back from you.

Thank you so much and I hope everyone has a lovely Thanksgiving!
[redacted]

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 22, 2022 3:44 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: Please review: Stewardship report for [redacted]

This is terrific. Attached, my edits. See what you think.

Best,
[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, November 18, 2022 3:39 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted]@ucsf.edu>

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Subject: Please review: Stewardship report for [redacted]

Hello [redacted] and Stephen,
I hope you both are doing well. I have thoroughly enjoyed getting to know you both in our interview and then writing this report (with help from*your* report)! I am so very grateful to you both for doing this work.

Attached is the report to Mr. [redacted]. I wrote through your report and added details from our interview -- there is one question to answer.

If you could please review the draft for accuracy and send it back to me by Monday, Nov. 28 we could send it out in November. Please let me know if you have any questions.

Thanks again for your time and your amazing work.
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, October 18, 2022 4:13 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: Re: Interview Friday, 10.21.22? Re: Introductions - Stewardship report for [redacted]

I'm available 1 pm or 3 pm.

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, October 18, 2022 2:59 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: Interview Friday, 10.21.22? Re: Introductions - Stewardship report for [redacted]

Hello again,
Forgive the gentle nudge. But I am hoping to schedule this interview for Friday, and I wanted to reach out again to you, Dr. [redacted], to see if you are available at 1 pm, 2 pm or 3 pm on Friday, Oct. 21?

As I understand it from [redacted], these are the points we want to cover in the report:

- Established new position Director of Advocacy and recruited highly sought-after candidate
- Moving into the Pritzker building
- Hiring new position: Director of Education
- Strengthened community partnership with Mind the Gap (providers with gender affirming approach who accept referrals form UCSF)
- Hired [redacted], RN, who is fluent in Cantonese and English.

Crossing my fingers that Friday afternoon will work for you, Dr. [redacted].
Thanks so much,
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 14, 2022 1:54 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: Re: Introductions - Stewardship report for [redacted]

Hello Steve,
Thanks so much for your prompt reply !I can meet at 1 pm, 2 pm or 3 pm on Friday, Oct. 21.

[redacted], I am hoping one of those times works for you. Once we have confirmed, I will send a zoom invite.

Best,
[redacted]

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 14, 2022 1:50 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Introductions - Stewardship report for [redacted]

Hi [redacted],

Nice to meet you! I would be happy to be present with [redacted] for the entire interview. I believe Friday afternoons are best for [redacted], and I'm available starting at 1 PM on 10/21 (pending one potential conflict).

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 14, 2022 12:29 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Introductions - Stewardship report for [redacted]

Hello Dr. Rosenthal and Dr. [redacted],

Thanks, [redacted], for your introduction. I write stewardship reports for UCSF, and I am eager to talk to you both about this gift. It can be difficult to interview two people at the same time -- so if I can focus on one person for one part of the story and the other person for the other part of the story, that might be the most efficient way to handle this. And if you would both like to be present for the entire interview -- that's fine.

If you could send me times and days that you are both available during the next week -- that would be greatI would like to handle this interview before Oct. 25 because I will be gone for a week starting Oct. 26. I hope that doesn't make this too inconvenient.

I look forward to hearing from you.
Thanks so much,
[redacted]

[redacted]
Senior Donor Relations Writer, Advanced Communications
University Development & Alumni Relations

University of California, San Francisco
2001 The Embarcadero, 3rd Floor | Box 0248
San Francisco, CA 94143
mobile: [redacted]
[redacted]@ucsf.edu

UCSF

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 14, 2022 12:11 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>

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Subject: Introductions - Stewardship report for [redacted]

Good morning Steve and [redacted],

I'd like to introduce you to my esteemed colleague [redacted] who is drafting a stewardship report for [redacted].
You might recall Mr. [redacted] gave last year per [redacted]'s request.

[redacted] would like to speak with you about the highlights that should be included. I suggested:

- Established new position Director of Advocacy and recruited highly sought-after candidate
- Moving into the Pritzker building
- Hiring for a new position Director of Education
- Strengthened community partnership with Mind the Gap
- Hired [redacted], RN, who is fluent in Cantonese and English.

I will not be part of the meeting with you and [redacted], so I will defer to her on scheduling.

Best,
[redacted]

UCSF Benioff Children's Hospitals

[redacted]
Director of Development,
Children's Health
Pronouns: *she, her, hers*

C [redacted]
E [redacted]@ucsf.edu

UCSF Benioff Children's Hospitals Foundation

give.ucsfbenioffchildrens.org

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 22, 2022 7:52 PM PST
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: NPR Los Angeles -- Interview Inquiry
Attachment(s): "USPATHWPATH Statement re Nov 14 2022 NYT Article Nov 22 2022.pdf"

Hi [redacted],

Should you decide to do this interview, you may find the statement in response to the NYT article from the USPATH BOD and WPATH EC to be useful. It was posted today.

Best wishes,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, November 22, 2022 3:01 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: NPR Los Angeles -- Interview Inquiry

Sure thing, I'll send you a link in a second!

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, November 22, 2022 2:59 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: NPR Los Angeles -- Interview Inquiry

Can we plan to chat at 11am tomorrow? Zoom would be great if that works for you?
Thank you,
[redacted]

Get Outlook for iOS

From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, November 22, 2022 9:00:43 AM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: NPR Los Angeles -- Interview Inquiry

Hi [redacted],
Sure, I'd be glad to talk. I'm free at 4pm Tues or 11 am Wed; does one of those work for you? And would you prefer Zoom or phone?
Best, [redacted]

[redacted]

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Obtained via CPRA by Judicial Watch, Inc.

Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 21, 2022 8:44 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: NPR Los Angeles -- Interview Inquiry

Hi [redacted]

Thanks so much for your reply. I spoke with [redacted] today in clinic and heard from Steve too, so thank you all. I appreciate the clarification and appreciate your guidance and partnership in these matters.

Might you have time to discuss further tomorrow (Tuesday) afternoon or Wednesday morning? If not, then perhaps we could aim for some time next week after the holiday?

Thank you,
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Date: Monday, November 21, 2022 at 8:57 AM
To: [redacted] <[redacted]@ucsf.edu>, Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>
Subject: Re: NPR Los Angeles -- Interview Inquiry

Hi [redacted], It's probably easiest to have a phone or Zoom conversation about this. Do you have time this week to discuss? I can explain the POV of the Office of Comms. The short answer is, as media experts, UCSF Comms advises faculty on what we think the best course forward is for media requests. At this point in time, and after very careful thought and research on the matter, we don't think most interviews are a net benefit. Having said that, faculty are of course welcome to proceed as they wish; we just ask for a heads up so we can be prepared to handle any repercussions.
Please let me know if/when you may want to discuss; very happy to do so!
Best,
[redacted]

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Sunday, November 20, 2022 1:41 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: NPR Los Angeles -- Interview Inquiry

Hi all,

Writing to ask, are we allowed to accept interviews on this topic right now, or have we been asked by UCSF to not accept any interviews?

I understand that there may not be a big benefit to UCSF or our patients, but there may be a benefit to patients and other medical professionals across the country in less affirming environments. I think that our current climate is going to require that those of us in more supportive environments help lead the way through these tenuous times. I know it's very complicated right now and that we certainly need to carefully consider which if any interview requests to accept after vetting them and considering their intended slant / objectives.

Thanks for your thoughts and input,
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Date: Wednesday, November 16, 2022 at 12:35 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>

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Subject: Re: NPR Los Angeles -- Interview Inquiry

Sorry, my cat decided to send that message early. Was just affirming your decision- not a big benefit to UCSF or our patients in doing interviews on this topic right now. Thanks for keeping me posted. [redacted]

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, November 16, 2022 12:32 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: NPR Los Angeles -- Interview Inquiry

Thanks for keeping me in the loop. I don't see a benefit to UCSF or interviews on this topic right now, to UCSF or

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 16, 2022 12:19 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: NPR Los Angeles -- Interview Inquiry

I already turned it down.
Steve

Get Outlook for iOS

From: [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, November 16, 2022 11:56:00 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Fwd: NPR Los Angeles -- Interview Inquiry

FYI media inquiry. I have clinic tomorrow AM so am not available

[redacted], MD, MPH, MAS
Assistant Professor of Pediatrics and of Medicine
Divisions of Pediatric Endocrinology and Endocrinology & Metabolism
Assistant Medical Director, Child and Adolescent Gender Center
University of California, San Francisco

Mission Hall
550 16th St, 4th Floor, Box 0434
San Francisco, CA 94143
E-mail: [redacted]@ucsf.edu
She/Her/Hers

From: [redacted]@ufl.edu>
Sent: Wednesday, November 16, 2022 11:52:41 AM
To: [redacted]@ufl.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@peds.ufl.edu>
Subject: Re: NPR Los Angeles -- Interview Inquiry

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This message came from outside your organization.

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Hi [redacted],

NPR in Pasadena is looking to interview a peds endo about the use of puberty blockers in transgender youth, especially in reference to the recent NYT article. [redacted] was recommended, but she isn't available and is also in Florida. Since you're an expert in this area and in California, would you be available to do the interview? It's tomorrow 10-10:40 AM. If not, would Dr. [redacted] or another peds endo in California be available?

Thanks!!
[redacted]

Sent from my iPhone

On Nov 16, 2022, at 12:50 PM, [redacted]@ufl.edu> wrote:

Would either of you be willing/able to talk to NPR LA tomorrow about puberty blockers?

From: Lucy Copp <lcopp@scpr.org>
Sent: Tuesday, November 15, 2022 5:04 PM
To: [redacted]@bidmc.harvard.edu>
Cc: [redacted]@ufl.edu>
Subject: Re: NPR Los Angeles -- Interview Inquiry

[External Email]
Hi [redacted],

Thanks for the reply and recommendation!

[redacted], let me know if you're available for this conversation. If so, I'd love to connect.

Thanks all,

Lucy

From: [redacted]@bidmc.harvard.edu>
Sent: Tuesday, November 15, 2022 4:57 PM
To: Lucy Copp <lcopp@scpr.org>
Cc: [redacted]@peds.ufl.edu <[redacted]@peds.ufl.edu>
Subject: RE: NPR Los Angeles -- Interview Inquiry

[External Content] This message is from an external source. Please exercise caution when opening attachments or links.
Hi Lucy,

I suggest that you contact a pediatric endocrinologist as they prescribe puberty blockers. As an adult endocrinologist I don't prescribe them.

I also am in clinic on [redacted]

I've copied [redacted] who is a peds endo at the University of Florida to see if she would be interested.

Take care,

[redacted] *(pronouns: he/him/his)*
Associate Professor of Medicine, Harvard Medical School
Director of Transgender Medicine at Beth Israel Deaconess Medical Center

Division of Endocrinology, Diabetes & Metabolism
330 Brookline Ave, GZ6, Boston MA 02215
T: [redacted] F: [redacted]
E: [redacted]@bidmc.harvard.edu

Associate Editor for *Andrology & Sexual Medicine Reviews*

From: Lucy Copp <lcopp@scpr.org>
Sent: Tuesday, November 15, 2022 4:48 PM

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

To: [redacted]@bidmc.harvard.edu>
Subject: [External] NPR Los Angeles -- Interview Inquiry

Hi [redacted]

I'm a reporter at KPCC, an NPR affiliate station in Pasadena. I'm reaching out on behalf of our program AirTalk with Larry Mantle.

We're hoping to have a conversation on our program this **Thursday from 10 am to 10:40 am PST** about puberty blockers from a medical standpoint. This conversation is coming from a recent NYT article that I sent to our team. We think it'd be an interesting and important conversation to have on our program. We will likely have one of the reporters join us and if are comfortable speaking on this topic, I'd love to see if you might be available for this discussion as well. If so, I'd love to find a time to chat briefly!

Let me know what works for you.

Thanks very much,

Lucy

Lucy Copp (she/her)

Associate Producer, AirTalk with Larry Mantle
Southern California Public Radio
474 S Raymond Avenue
Pasadena, CA 91105
401-952-2273 (cell)
kpcc.org |laist | @lucyacopp

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 22, 2022 8:51 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Please review: Stewardship report for [redacted]
Attachment(s):
"image001.png","image002.png","image003.png","image001.png","image002.png","image003.png","Pritzker.GenderCenter.11.18.22 D.E._SMR_ edits.docx"

Steve — thank you for your kind words! I am so happy you are also pleased.
I will make your edits and then [redacted] will ensure the report is sent. Fingers crossed that I get to talk to you soon about another gift to your lifesaving work. I am grateful to you both.
All my best to you, [redacted] and Steve,
[redacted]

Sent from my iPhone

> On Nov 22, 2022, at 6:17 PM, Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu> wrote:
>
> Dear [redacted]
>
> I agree with [redacted]—this is terrific! I really appreciate all the thought and care that went into it!
> i have made a few small edits on the attached.
>
> Thanks, and Happy Thanksgiving!
>
> Steve
>
> Stephen M. Rosenthal, M.D.
> Professor of Pediatrics
> Division of Pediatric Endocrinology
> Medical Director, Child and Adolescent Gender Center
> University of California, San Francisco
> Mission Hall: Global Health and Clinical Sciences
> 550 16th St., 4th Floor, #4635
> San Francisco CA 94143-0434
> Pronouns: he/him/his
>
> Director, World Professional Association for Transgender Health
> Past Vice President and Director, Endocrine Society
> Past President, Pediatric Endocrine Society
>
> Tel.: (415) 476-2266
> Fax: (415) 476-5356
> email: Stephen.Rosenthal@ucsf.edu
>
> ---
>
> **From:** [redacted]@ucsf.edu>
> **Sent:** Tuesday, November 22, 2022 3:49 PM
> **To:** [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
> **Cc:** [redacted]@ucsf.edu>
> **Subject:** Re: Please review: Stewardship report for [redacted]
>
> I am so very glad to hear you are pleased, [redacted]. And I will incorporate your edits.
>
> Steve, have you had a chance to review? Oh, I see your OOO is on. I will wait to hear back from you.
>
> Thank you so much and I hope everyone has a lovely Thanksgiving!
> [redacted]
>
> ---
>
> **From:** [redacted]@ucsf.edu>
> **Sent:** Tuesday, November 22, 2022 3:44 PM
> **To:** [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
> **Cc:** [redacted]@ucsf.edu>
> **Subject:** Re: Please review: Stewardship report for [redacted]
>
> This is terrific. Attached, my edits. See what you think.
>
> Best,
> [redacted]
>
> [redacted], Ph.D.

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, November 18, 2022 3:39 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Please review: Stewardship report for [redacted]

Hello [redacted] and Stephen,
I hope you both are doing well. I have thoroughly enjoyed getting to know you both in our interview and then writing this report (with help from*your* report)! I am so very grateful to you both for doing this work.

Attached is the report to Mr. [redacted]. I wrote through your report and added details from our interview -- there is one question to answer.

If you could please review the draft for accuracy and send it back to me by Monday, Nov. 28 we could send it out in November. Please let me know if you have any questions.

Thanks again for your time and your amazing work.
[redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, October 18, 2022 4:13 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: Interview Friday, 10.21.22? Re: Introductions - Stewardship report for [redacted]

I'm available 1 pm or 3 pm.

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, October 18, 2022 2:59 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Interview Friday, 10.21.22? Re: Introductions - Stewardship report for [redacted]

Hello again,
Forgive the gentle nudge. But I am hoping to schedule this interview for Friday, and I wanted to reach out again to you, Dr. [redacted], to see if you are available at 1 pm, 2 pm or 3 pm on Friday, Oct. 21?

As I understand it from [redacted], these are the points we want to cover in the report:

- Established new position Director of Advocacy and recruited highly sought-after candidate
- Moving into the Pritzker building
- Hiring new position: Director of Education
- Strengthened community partnership with Mind the Gap (providers with gender affirming approach who accept referrals form UCSF)
- Hired [redacted], RN, who is fluent in Cantonese and English.

Crossing my fingers that Friday afternoon will work for you, Dr. [redacted].
Thanks so much,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Friday, October 14, 2022 1:54 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: Introductions - Stewardship report for [redacted]

Hello Steve,

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Thanks so much for your prompt reply ! I can meet at 1 pm, 2 pm or 3 pm on Friday, Oct. 21.

[redacted], I am hoping one of those times works for you. Once we have confirmed, I will send a zoom invite.

Best,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 14, 2022 1:50 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Subject: Re: Introductions - Stewardship report for [redacted]

Hi [redacted]

Nice to meet you! I would be happy to be present with [redacted] for the entire interview. I believe Friday afternoons are best for [redacted], and I'm available starting at 1 PM on 10/21 (pending one potential conflict).

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 14, 2022 12:29 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Subject: Re: Introductions - Stewardship report for [redacted]

Hello Dr. Rosenthal and Dr. [redacted],

Thanks, [redacted], for your introduction. I write stewardship reports for UCSF, and I am eager to talk to you both about this gift. It can be difficult to interview two people at the same time -- so if I can focus on one person for one part of the story and the other person for the other part of the story, that might be the most efficient way to handle this. And if you would both like to be present for the entire interview -- that's fine.

If you could send me times and days that you are both available during the next week -- that would be great I would like to handle this interview before Oct. 25 because I will be gone for a week starting Oct. 26. I hope that doesn't make this too inconvenient.

I look forward to hearing from you.
Thanks so much,
[redacted]

[redacted]
Senior Donor Relations Writer, Advanced Communications
University Development & Alumni Relations

University of California, San Francisco
2001 The Embarcadero, 3rd Floor | Box 0248
San Francisco, CA 94143
mobile: [redacted]
[redacted]@ucsf.edu

UCSF

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From: [redacted]@ucsf.edu>
Sent: Friday, October 14, 2022 12:11 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Introductions - Stewardship report for [redacted]

Good morning Steve and [redacted],

I'd like to introduce you to my esteemed colleague [redacted] who is drafting a stewardship report for [redacted]. You might recall Mr. [redacted] gave last year per [redacted]s request.

[redacted] would like to speak with you about the highlights that should be included. I suggested:

- Established new position Director of Advocacy and recruited highly sought-after candidate
- Moving into the Pritzker building
- Hiring for a new position Director of Education
- Strengthened community partnership with Mind the Gap
- Hired [redacted], RN, who is fluent in Cantonese and English.

I will not be part of the meeting with you and [redacted] so I will defer to her on scheduling.

Best,
[redacted]

[redacted]
Director of Development,
Children's Health
Pronouns: *she, her, hers*

C ([redacted]) [redacted]
E [redacted]@ucsf.edu

UCSF Benioff Children's Hospitals Foundation

give.ucsfbenioffchildrens.org

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, November 23, 2022 11:00 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
CC: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Good morning everyone,

[redacted] and I had a productive meeting with [redacted] last week about how to use this transitional time to better streamline patients' entry into the CAGC clinic.

Our understanding of the current state is: [redacted] contacts all patients with new patient appointments in the upcoming month, and completes the following questionnaire over the phone. This information is then put into the chart for providers to have at the ready for the patient's first visit. Copy of the assessment is here:
CAGC First Visit Questionnaire (1).docx

Our proposal for changes to make: [redacted] will conduct a simplified version of the questionnaire with families over the phone when she calls to schedule them. A week before their appointment, she will do a reminder call & offer to have a Social Worker ([redacted]) contact them for any additional support needs. Additionally, if [redacted] identifies any potential complicating psychosocial factors during her phone conversations with families (ie unclear custody arrangement, patient with significant mental health concerns, transportation/insurance access issues, etc), [redacted] will send a referral to [redacted] via the Apex referral system for follow-up.

Curious to know a few things...

1. What are your initial thoughts/responses/concerns to this proposed change of workflow?
2. Is a SWer required to make contact with every patient, or is it permissible for it to be as-indicated?
3. Can this questionnaire be simplified at all?

Happy to sit and have a meeting about this if you'd prefer! Thanks again for your partnership.

[redacted] & [redacted]

[redacted] LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 4:23 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted],

The DPH grant is ending as of 11/30/22, so all CAGC Social Work support going forward will be from the Medical Center. I'm hoping you and [redacted] can soon resolve the total Social Work FTE.

Please keep me posted on the search for the new CAGC Social Worker position.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center

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University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 4:00 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: RE: CAGC SW

Hello,

I was also under the impression that we had 2x 0.9 positions, but recently heard differently and was told we have 1.6 total for CACG. I will continue to explore this further.
If we actually do have only 1.6, do we still have access to the .3 FTE from the DPH grant?

Also, we have hired for the 2nd position, [redacted], MSW is set to start on 11/7. We will send out a bio to the team soon.
I submitted an eRF to replace [redacted] and am waiting for this to be approved and posted.

Thank you,
[redacted], **LCSW**
Pediatric Social Work Manager
UCSF Benioff Children's Hospital, San Francisco

Pediatric Social Work Department
1975 4th Street, Box 4012 | San Francisco, CA 94158
Office: 415.514-7668
Email: [redacted]@ucsf.edu
Pronouns: she, hers, her, ella

UCSF Benioff Children's Hospitals

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 3:21 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi All,

I have cc'd [redacted]. We (the CAGC) have had a 0.9 FTE Social Worker paid for by the Medical Center, and, as on 2/17/22 (see email from [redacted] below), we were awarded an additional 0.9 FTE Social Worker based on the needs of the CAGC. Therefore, we should have two Social Workers, each at 0.9 FTE for the CAGC ASAP --The funding for the 2nd Social Worker was approved 8 months ago!

I understand that we have a replacement for the position currently held by [redacted], who will be leaving UCSF as of 11/11/22.

Please let me know if the position for the 2nd Social Worker has been posted, and if not yet posted, please let me know when this is likely to happen. Again, the funding for the 2nd Social Worker was approved 8 months ago, so we really need to move forward with the hiring process.

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Thank you,

Steve

From: [redacted], Jason <[redacted]@ucsf.edu>
Sent: Thursday, February 17, 2022 4:42 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: CAGC FTE Requests

All,

I have great news!

We received final approval on the 4.9 FTE investment request for CAGC. The positions are currently being posted by HR. Here's what was approved:

- 1.0 FTE Psychologist
- 1.0 FTE Practice Coordinator
- 0.9 FTE Social Worker
- 1.0 FTE LVN
- 1.0 FTE RN

I want to thank all of you for your patience as we worked to get this to the finish line. I also want to give kudos to [redacted] for her leadership in getting the request organized and building a compelling business case!

Thanks,

[redacted]

[redacted], MBA
Director
Children's Ambulatory Services
UCSF Health

Office: (415) 514-6388
Mobile: [redacted]

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 3:02 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: CAGC SW

Hi,

Please contact Steve and [redacted] regarding that information.

Thank you,

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Obtained via CPRA by Judicial Watch, Inc.

Dr. [redacted], DNP, AC-PNP-BC
Nurse Practitioner
UCSF Pediatric Endocrinology

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:18 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks [redacted].

Any info on where the funding from the other .9 FTE is from, if it's not also Medical Center?

Thanks,
[redacted]

[redacted], LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:17 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: CAGC SW

Here is the response on SW FTE:

2 x 0.9 FTE and one of those 0.9 FTE is from med center

[redacted], PNP
UCSF Pediatric Endocrinology
Assistant Clinical Professor
Department of Family Health Care
UCSF School of Nursing

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 23, 2022 12:01 PM PST
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted],

I think that the particular knowledge and skills that a social worker brings to patient care makes it preferable for a social worker to have contact with every new family before their initial CAGC appointment. In terms of potential modification to the survey, I would propose asking for [redacted] input, given they have had the most experience with the survey, and I understand [redacted] is with UCSF until 12/2.

Thanks, and Happy Thanksgiving,

Steve

Get Outlook for iOS

From: [redacted]@ucsf.edu>
Sent: Wednesday, November 23, 2022 2:00:20 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Good morning everyone,

[redacted] and I had a productive meeting with [redacted] last week about how to use this transitional time to better streamline patients' entry into the CAGC clinic.

Our understanding of the current state is: [redacted] contacts all patients with new patient appointments in the upcoming month, and completes the following questionnaire over the phone. This information is then put into the chart for providers to have at the ready for the patient's first visit. Copy of the assessment is here:
CAGC First Visit Questionnaire (1).docx

Our proposal for changes to make: [redacted] will conduct a simplified version of the questionnaire with families over the phone when she calls to schedule them. A week before their appointment, she will do a reminder call & offer to have a Social Worker ([redacted]) contact them for any additional support needs. Additionally, if [redacted] identifies any potential complicating psychosocial factors during her phone conversations with families (ie unclear custody arrangement, patient with significant mental health concerns, transportation/insurance access issues, etc), [redacted] will send a referral to [redacted] via the Apex referral system for follow-up.

Curious to know a few things...

1. What are your initial thoughts/responses/concerns to this proposed change of workflow?
2. Is a SWer required to make contact with every patient, or is it permissible for it to be as-indicated?
3. Can this questionnaire be simplified at all?

Happy to sit and have a meeting about this if you'd prefer! Thanks again for your partnership.

[redacted] & [redacted]

[redacted], LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
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San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 4:23 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted], Jason <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted],

The DPH grant is ending as of 11/30/22, so all CAGC Social Work support going forward will be from the Medical Center. I'm hoping you and [redacted] can soon resolve the total Social Work FTE.

Please keep me posted on the search for the new CAGC Social Worker position.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 4:00 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: RE: CAGC SW

Hello,

I was also under the impression that we had 2x 0.9 positions, but recently heard differently and was told we have 1.6 total for CACG. I will continue to explore this further.
If we actually do have only 1.6, do we still have access to the .3 FTE from the DPH grant?

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I submitted an eRF to replace [redacted] and am waiting for this to be approved and posted.

Thank you,

[redacted], **LCSW**
Pediatric Social Work Manager
UCSF Benioff Children's Hospital, San Francisco

Pediatric Social Work Department
1975 4th Street, Box 4012 | San Francisco, CA 94158
Office: 415.514-7668
Email: [redacted]@ucsf.edu
Pronouns: she, hers, her, ella

UCSF Benioff Children's Hospitals

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 3:21 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi All,

I have cc'd [redacted]. We (the CAGC) have had a 0.9 FTE Social Worker paid for by the Medical Center, and, as on 2/17/22 (see email from [redacted], below), we were awarded an additional 0.9 FTE Social Worker based on the needs of the CAGC. Therefore, we should have two Social Workers, each at 0.9 FTE for the CAGC ASAP --The funding for the 2nd Social Worker was approved 8 months ago!

I understand that we have a replacement for the position currently held by [redacted] who will be leaving UCSF as of 11/11/22.

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Thank you,

Steve

From: [redacted]@ucsf.edu>
Sent: Thursday, February 17, 2022 4:42 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC FTE Requests

All,

I have great news!

We received final approval on the 4.9 FTE investment request for CAGC. The positions are currently being posted by HR. Here's what was approved:

- 1.0 FTE Psychologist
- 1.0 FTE Practice Coordinator
- 0.9 FTE Social Worker
- 1.0 FTE LVN
- 1.0 FTE RN

I want to thank all of you for your patience as we worked to get this to the finish line. I also want to give kudos to [redacted] for her leadership in getting the request organized and building a compelling business case!

Thanks,

[redacted]

[redacted], MBA
Director
Children's Ambulatory Services
UCSF Health

Office: (415) 514-6388
Mobile: [redacted]

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434

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Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 3:02 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: CAGC SW

Hi,

Please contact Steve and [redacted] regarding that information.

Thank you,

Dr. [redacted], DNP, AC-PNP-BC
Nurse Practitioner
UCSF Pediatric Endocrinology

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:18 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks [redacted].

Any info on where the funding from the other .9 FTE is from, if it's not also Medical Center?

Thanks,
[redacted]

[redacted], LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:17 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: CAGC SW

Here is the response on SW FTE:

2 x 0.9 FTE and one of those 0.9 FTE is from med center

[redacted], PNP
UCSF Pediatric Endocrinology
Assistant Clinical Professor
Department of Family Health Care
UCSF School of Nursing

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Obtained via CPRA by Judicial Watch, Inc.

From: [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, November 23, 2022 12:32 PM PST
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks, [redacted], for putting so much thought into this. I feel strongly that the social worker, not the scheduler, takes full responsibility for any pre-clinic contact with the family aside from the scheduling. The pre-clinic questionnaire and social work contact is actually the beginning of the gender care prior to the first visit and requires someone trained to take on this role. To date, the social work team has been invaluable in this regard.

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, November 23, 2022 11:00 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Good morning everyone,

[redacted] and I had a productive meeting with [redacted] last week about how to use this transitional time to better streamline patients' entry into the CAGC clinic.

Our understanding of the current state is: [redacted] contacts all patients with new patient appointments in the upcoming month, and completes the following questionnaire over the phone. This information is then put into the chart for providers to have at the ready for the patient's first visit. Copy of the assessment is here:
CAGC First Visit Questionnaire (1).docx

Our proposal for changes to make: [redacted] will conduct a simplified version of the questionnaire with families over the phone when she calls to schedule them. A week before their appointment, she will do a reminder call & offer to have a Social Worker ([redacted]) contact them for any additional support needs. Additionally, if [redacted] identifies any potential complicating psychosocial factors during her phone conversations with families (ie unclear custody arrangement, patient with significant mental health concerns, transportation/insurance access issues, etc), [redacted] will send a referral to [redacted] via the Apex referral system for follow-up.

Curious to know a few things...

1. What are your initial thoughts/responses/concerns to this proposed change of workflow?
2. Is a SWer required to make contact with every patient, or is it permissible for it to be as-indicated?
3. Can this questionnaire be simplified at all?

Happy to sit and have a meeting about this if you'd prefer! Thanks again for your partnership.

[redacted] & [redacted]

[redacted], LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
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original message.

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 4:23 PM
To: [redacted]
Cc: [redacted]
Subject: Re: CAGC SW

Hi [redacted],

The DPH grant is ending as of 11/30/22, so all CAGC Social Work support going forward will be from the Medical Center. I'm hoping you and [redacted] can soon resolve the total Social Work FTE.

Please keep me posted on the search for the new CAGC Social Worker position.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
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Pronouns: he/him/his

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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]
Sent: Friday, October 28, 2022 4:00 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]
Cc: [redacted]
Subject: RE: CAGC SW

Hello,

I was also under the impression that we had 2x 0.9 positions, but recently heard differently and was told we have 1.6 total for CACG. I will continue to explore this further.
If we actually do have only 1.6, do we still have access to the .3 FTE from the DPH grant?

Also, we have hired for the 2nd position, [redacted], MSW is set to start on 11/7. We will send out a bio to the team soon.
I submitted an eRF to replace [redacted] and am waiting for this to be approved and posted.

Thank you,

[redacted], **LCSW**
Pediatric Social Work Manager
UCSF Benioff Children's Hospital, San Francisco

Pediatric Social Work Department
1975 4th Street, Box 4012 | San Francisco, CA 94158
Office: 415.514-7668
Email: [redacted]@ucsf.edu
Pronouns: she, hers, her, ella

UCSF Benioff Children's Hospitals

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 3:21 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi All,

I have cc'd [redacted]. We (the CAGC) have had a 0.9 FTE Social Worker paid for by the Medical Center, and, as on 2/17/22 (see email from [redacted], below), we were awarded an additional 0.9 FTE Social Worker based on the needs of the CAGC. Therefore, we should have two Social Workers, each at 0.9 FTE for the CAGC ASAP --The funding for the 2nd Social Worker was approved 8 months ago!

I understand that we have a replacement for the position currently held by [redacted], who will be leaving UCSF as of 11/11/22.

Please let me know if the position for the 2nd Social Worker has been posted, and if not yet posted, please let me know when this is likely to happen. Again, the funding for the 2nd Social Worker was approved 8 months ago, so we really need to move forward with the hiring process.

Thank you,

Steve

From: [redacted]@ucsf.edu>
Sent: Thursday, February 17, 2022 4:42 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC FTE Requests

All,

I have great news!

We received final approval on the 4.9 FTE investment request for CAGC. The positions are currently being posted by HR. Here's what was approved:

- 1.0 FTE Psychologist
- 1.0 FTE Practice Coordinator
- 0.9 FTE Social Worker
- 1.0 FTE LVN
- 1.0 FTE RN

I want to thank all of you for your patience as we worked to get this to the finish line. I also want to give kudos to Jo for her leadership in getting the request organized and building a compelling business case!

Thanks,

[redacted]

[redacted], MBA
Director
Children's Ambulatory Services
UCSF Health

Office: (415) 514-6388
Mobile: [redacted]

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Professor of Pediatrics
Division of Pediatric Endocrinology
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San Francisco CA 94143-0434
Pronouns: he/him/his

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Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 3:02 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: CAGC SW

Hi,

Please contact Steve and [redacted] regarding that information.

Thank you,

Dr. [redacted], DNP, AC-PNP-BC
Nurse Practitioner
UCSF Pediatric Endocrinology

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:18 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks [redacted]

Any info on where the funding from the other .9 FTE is from, if it's not also Medical Center?

Thanks,
[redacted]

[redacted], LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:17 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: CAGC SW

Here is the response on SW FTE:

2 x 0.9 FTE and one of those 0.9 FTE is from med center

[redacted], PNP
UCSF Pediatric Endocrinology
Assistant Clinical Professor
Department of Family Health Care
UCSF School of Nursing

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 24, 2022 10:56 AM PST
To: [redacted]@chla.usc.edu>
Subject: Fw: NIHMS1845428: Manuscript available in PMC

FYI

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: nihms-help@ncbi.nlm.nih.gov <nihms-help@ncbi.nlm.nih.gov>
Sent: Saturday, November 19, 2022 10:03 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: NIHMS1845428: Manuscript available in PMC

"Growth in transgender/gender-diverse youth in the first year of treatment with gonadotropin-releasing hormone agonists" (NIHMS1845428)

Dear NIHMS Customer,

You are receiving this email because you are associated with the above-listed manuscript in the NIH Manuscript Submission (NIHMS) system. The manuscript is now available in PubMed Central (PMC) for public access in compliance with the funder's public access policy (see https://urldefense.com/v3/__https://www.nihms.nih.gov/about/publicaccess__;!!LQC6Cpwp!o5X5wYaxc6nDilcyY7QVA8pc22244TC1Wc4HagLAmpqNQdpwqIGViualQd7c1C-yGMSylQrGMrKq8Rysx8Dxiu96qk400GR1wQ$):

https://urldefense.com/v3/__https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9673472__;!!LQC6Cpwp!o5X5wYaxc6nDilcyY7QVA8pc22244TC1Wc4HagLAmpqNQdpwqIGViualQd7c1C-yGMSylQrGMrKq8Rysx8Dxiu96qk6i4epW3w$

The submission process for this manuscript is complete. As always, please feel free to contact us with any questions at nihms-help@ncbi.nlm.nih.gov.

Thank you,

The NIHMS Help Desk

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 24, 2022 11:09 AM PST
To: [redacted]@scdi.org.vn>
CC: [redacted]@ucsf.edu>; [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

Dear [redacted],

It's very nice to hear from you! I apologize for my delayed response—just a very busy time. I would be able to meet with you during the day on Tuesday, January 3rd, starting at 1 PM. Our full Child and Adolescent Gender Center team is not currently meeting in person because of the pandemic, but rather by telehealth. However, I have cc'd my colleague, Dr. [redacted], whom you met in Hanoi, who may also be available to meet on the afternoon of January 3rd. Please let me know if January 3rd at 1 PM works for you, and i can send you details of where we can meet. I have also cc'd Dr. [redacted], in the event that she is also able to meet at that time.

Best wishes,

Sincerely,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@scdi.org.vn>
Sent: Tuesday, November 15, 2022 6:30 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: SCDI - Visit trip for services providers and policy makers from Vietnam

This Message Is From an External Sender
This message came from outside your organization.

Dear Dr. Stephen,
I hope this email finds you well. I am writing to you to share that we are currently arranging a visit trip for a team of 5 people: 1 surgeon, 1 endocrinologist, 1 psychologist, 1 SCDI officer and 1 person on the drafting team to Los Angeles to visit Dr. [redacted] hospital, community people and policy makers there to learn about the cooperate between 3 services for transgender people. As you may know that we are advocating for the drafted law on gender affirmation and under the drafted law, the Ministry of Health need to develop 2 guidelines on surgery and psychological support but the drafting team don't have any ideas for this. They have learnt from other countries via documents we and our partners provided for them. We expect with this trip, they will have the opportunity to better understand this coordination as well as the support needed for transgender people. I know Los Angeles is a very good practice to learn but I wonder if we have time, may we visit you, your hospital and meeting with community organization, policy makers (if applicable) in San Francisco. The team will be in U.S from 2 - 11 January 2023 and we can have 3 days in San Francisco.
Thank you very much and I am looking forward to hearing from you.

Warm regards,

[redacted]

SCDI
Develop Together
[redacted] (Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program

Obtained via CPRA by Judicial Watch, Inc.

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Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
SCDI | Số 9 ngách 30 ngõ 165 Thái Hà, P.Láng Hạ, Q.Đống Đa | Hanoi | Vietnam
T +84 (0)24 3572 0679 (số máy lẻ: 161) | F +84 (0)4 3572 0689 | M [redacted]
www.scdi.org.vn | www.facebook.com/scdivietnam | https://www.youtube.com/SCDIVietnam
One ream (500 sheets) of paper is equivalent to 5% of a tree. Please consider the trees before printing this email.

Obtained via CPRA by Judicial Watch, Inc.

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From: [redacted]@gmail.com>
Sent: Thursday, November 24, 2022 12:21 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
CC: [redacted]@gmail.com>; [redacted]@scdi.org.vn>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

This Message Is From an External Sender
This message came from outside your organization.

Dear All-

I somehow missed this email. I would be happy to meet then. Let me know as soon as you can regarding the time as it will involve rearranging my schedule, but that will not be a problem given advance notice. it will be wonderful to see you again. We can also arrange a time/place to socialize.

Best,

[redacted]

On Nov 24, 2022, at 11:09 AM, Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu> wrote:

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Steve

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Medical Director, Child and Adolescent Gender Center
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550 16th St., 4th Floor, #4635
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Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@scdi.org.vn>
Sent: Tuesday, November 15, 2022 6:30 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: SCDI - Visit trip for services providers and policy makers from Vietnam

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Thank you very much and I am looking forward to hearing from you.

Warm regards,

[redacted]

<Outlook-1496240420.png>
[redacted] (Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Commmunity Development Initiatives
SCDI | Số 9 ngách 30 ngõ 165 Phố Hạ, P.Láng Hạ, Q.Đống Đa | Hanoi | Vietnam
T +84 (0)24 3572 0679 (số máy lẻ: 161) | F +84 (0)4 3572 0689 | M [redacted]
www.scdi.org.vn | www.facebook.com/scdivietnam | https://www.youtube.com/SCDIVietnam
One ream (500 sheets) of paper is equivalent to 5% of a tree. Please consider the trees before printing this email.

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From: [redacted]@gmail.com>
Sent: Thursday, November 24, 2022 12:27 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
CC: [redacted]@gmail.com>; [redacted] <[redacted]@ucsf.edu>; [redacted]@sbcglobal.net>; [redacted]@csmc.edu>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

This Message Is From an External Sender
This message came from outside your organization.

Happy Thanksgiving all!
I want to send this out while I'm thinking of it.
I have a pie in the oven as I write!

Should we have dinner at our home? I know [redacted] will want to see everyone, too! It would be nice if [redacted] could come up.. Anyone else?

At any rate- as I said, I want to send this out and get back to my kitchen/. [redacted] and I are having a quiet meal thi year as we are still contagious but feeling fine. India was just amazing and I hope we can arrange another "Vietnam" type expedition. TBD.
More later,

Love,

[redacted]

On Nov 24, 2022, at 12:21 PM, [redacted]@gmail.com> wrote:

Dear All-

I somehow missed this email. I would be happy to meet then. Let me know as soon as you can regarding the time as it will involve rearranging my schedule, but that will not be a problem given advance notice. it will be wonderful to see you again. We can also arrange a time/place to socialize.

Best,

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San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5355
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@scdi.org.vn>
Sent: Tuesday, November 15, 2022 6:30 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: SCDI - Visit trip for services providers and policy makers from Vietnam

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Dear Dr. Stephen,
I hope this email finds you well. I am writing to you to share that we are currently arranging a visit trip for a team of 5 people: 1 surgeon, 1 endocrinologist, 1 psychologist, 1 SCDI officer and 1 person on the drafting team to Los Angeles to visit Dr. [redacted] hospital, community people and policy makers there to learn about the cooperate between 3 services for transgender people. As you may know that we are advocating for the drafted law on gender affirmation and under the drafted law, the Ministry of Health need to develop 2 guidelines on surgery and psychological support but the drafting team don't have any ideas for this. They have learnt from other countries via documents we and our partners provided for them. We expect with this trip, they will have the opportunity to better understand this coordination as well as the support needed for transgender people. I know Los Angeles is a very good practice to learn but I wonder if we have time, may we visit you, your hospital and meeting with community organization, policy makers (if applicable) in San Francisco. The team will be in U.S from 2 - 11 January 2023 and we can have 3 days in San Francisco.
Thank you very much and I am looking forward to hearing from you.

Warm regards,

[redacted]

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[redacted] Ms, Sme, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng / Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
SCDI | Số 9 ngách 30 ngõ 165 Thái Hà - P. Láng Hạ, Q. Đống Đa | Hanoi | Vietnam
T +84 (0)24 3572 0679 (số máy lẻ: 181) | F +84 (0)4 3572 0689 | M [redacted]
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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, November 25, 2022 6:43 PM PST
To: [redacted]@gmail.com>
Subject: Fwd: NYT Article
Attachment(s): "Puberty Blockers Can Help Transgender Youth. Is There a Cost_ - The New York Times.pdf"

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From: [redacted]@chla.usc.edu>
Sent: Monday, November 14, 2022 1:16 PM
To: [redacted]@luriechildrens.org>; [redacted]@chla.usc.edu>; [redacted]@childrens.harvard.edu>; [redacted]@chla.usc.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@chla.usc.edu>; [redacted]@chla.usc.edu>; [redacted]@luriechildrens.org>; [redacted]@childrens.harvard.edu>; [redacted]@luriechildrens.org>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@luriechildrens.org>; [redacted]@mednet.ucla.edu>
Subject: NYT Article

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Good morning,

The NYT article has been published. Here's the link, and I've attached a PDF

https://www.nytimes.com/2022/11/14/health/puberty-blockers-transgender.html

The link in the article to our study takes readers to the JMIR protocol paper.

Steve, you were quoted in the article around not prescribing stand-alone blockers to anyone over 14, and there's a link to your statement against the Alabama ban on medical treatment for trans youth.

Dr. Spack and Boston Children's Hospital are mentioned as leading the US adoption of blocker treatment.

Thanks,
[redacted]

[redacted]
She/her/hers
Clinical Research Manager
Division of Adolescent and Young Adult Medicine
Children's Hospital Los Angeles
4650 Sunset Blvd, MS 2
Los Angeles, CA 90027
[redacted]
[redacted]@chla.usc.edu
www.chla.org/adolhealth | @youthchla

I humbly acknowledge our presence on the traditional, ancestral, and unceded territory of the Gabrielino-Tongva peoples. I recognize that these Peoples were forcibly removed from their homelands. I take this opportunity to acknowledge the generations that have gone before as well as the present-day Gabrielino-Tongva people. With humility, I recognize and respect all Indigenous peoples, their histories, and their ties to the land. I also recognize the Chumash, Tataviam, Serrano, Cahuilla, Juaneno, and Luiseno People for the land that CHLA/USC occupies around Southern California. We pay respects to their past and present. Let this acknowledgement serve as an ongoing reminder of the original inhabitants where you reside.

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They Paused Puberty, but Is There a Cost?

Puberty blockers can ease transgender youths' anguish and buy time to weigh options. But concerns are growing about long-term physical effects and other consequences.

By Megan Twohey and Christina Jewett

Nov. 14, 2022 Updated 9:45 a.m. ET

The medical guidance was direct.

Eleven-year-old Emma Basques had identified as a girl since toddlerhood. Now, as she worried about male puberty starting, a Phoenix pediatrician advised: Take a drug to stop it.

At 13, Jacy Chavira felt increasingly uncomfortable with her maturing body and was beginning to believe she was a boy. Use the drug, her endocrinologist in Southern California recommended, and puberty would be suspended.

An 11-year-old in New York with deepening depression expressed a desire to no longer be a girl. A therapist told the family the drug was the preteen's best option, and a local doctor agreed.

"'Puberty blockers really help kids like this,'" the child's mother recalled the therapist saying. "It was presented as a tourniquet that would stop the hemorrhaging."

As the number of adolescents who identify as transgender grows, drugs known as puberty blockers have become the first line of intervention for the youngest ones seeking medical treatment.

Their use is typically framed as a safe — and reversible — way to buy time to weigh a medical transition and avoid the anguish of growing into a body that feels wrong. Transgender adolescents suffer from disproportionately high rates of depression and other mental health issues. Studies show that the drugs have eased some patients' gender dysphoria — a distress over the mismatch of their birth sex and gender identity.

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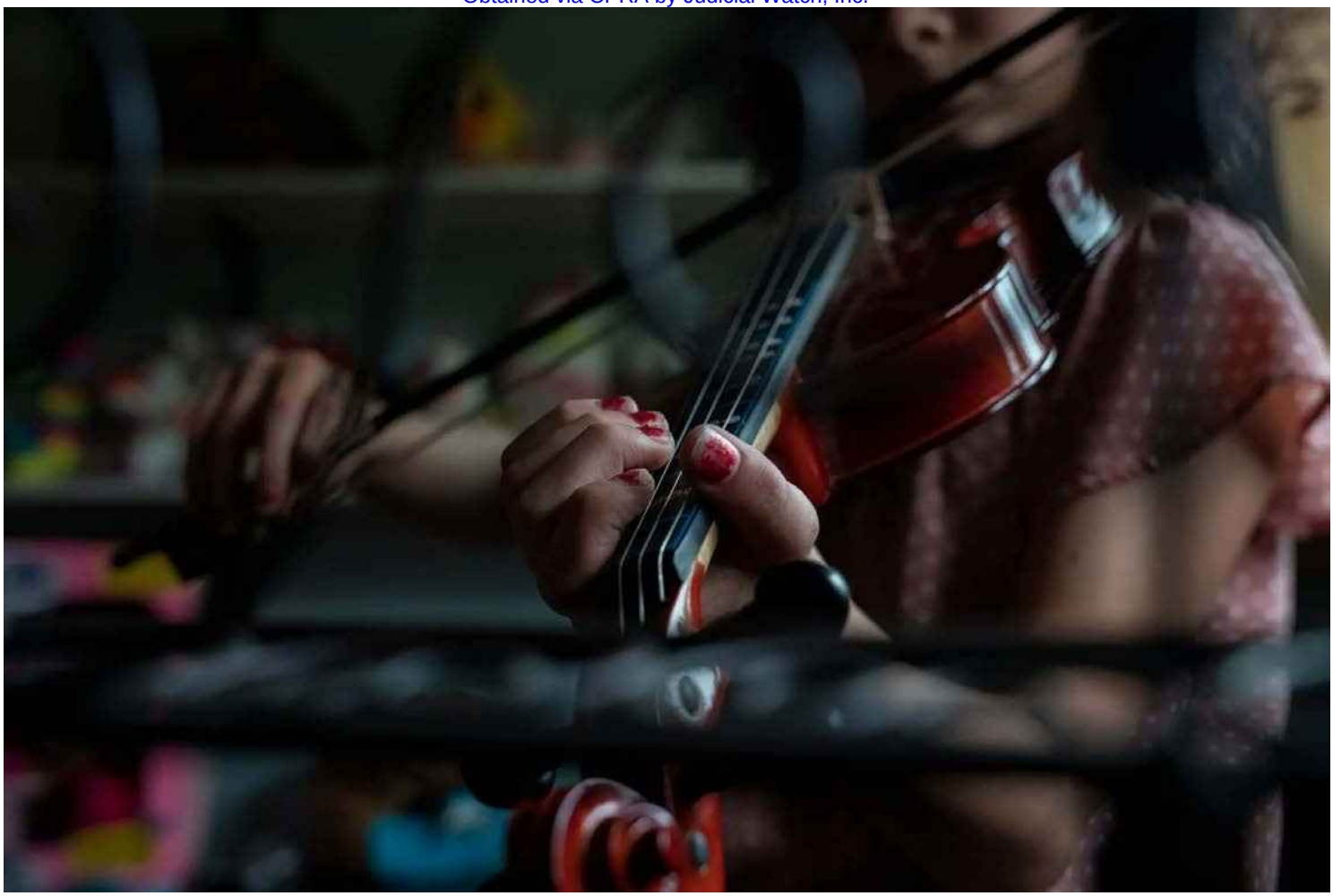

Emma, now 14, has identified as a girl since toddlerhood and feels that she's on the right path. Verónica G. Cárdenas for The New York Times

"Anxiety drains away," said Dr. Norman Spack, who pioneered the use of puberty blockers for trans youth in the United States and is one of many physicians who believe the drugs can be lifesaving. "You can see these kids being so relieved."

But as an increasing number of adolescents identify as transgender — in the United States, an estimated 300,000 ages 13 to 17 and an untold number who are younger — concerns are growing among some medical professionals about the consequences of the drugs, a New York Times examination found. The questions are fueling government reviews in Europe, prompting a push for more research and leading some prominent specialists to reconsider at what age to prescribe them and for how long. A small number of doctors won't recommend them at all.

Dutch doctors first offered puberty blockers to transgender adolescents three decades ago, typically following up with hormone treatment to help patients transition. Since then, the practice has spread to other countries, with varying protocols, little documentation of outcomes and no government approval of the drugs for that use, including by the U.S. Food and Drug Administration.

But there is emerging evidence of potential harm from using blockers, according to reviews of scientific papers and interviews with more than 50 doctors and academic experts around the world.

Behind Our Reporting on Puberty Blockers

Megan Twohey and Christina Jewett
Reporting for the Investigations Desk

As growing numbers of adolescents who identify as transgender are prescribed drugs to block puberty, the treatment is becoming a source of confusion and controversy.

We spent months scouring the scientific evidence, interviewing doctors around the world and speaking to patients and families.

Here's a closer look at what we found →

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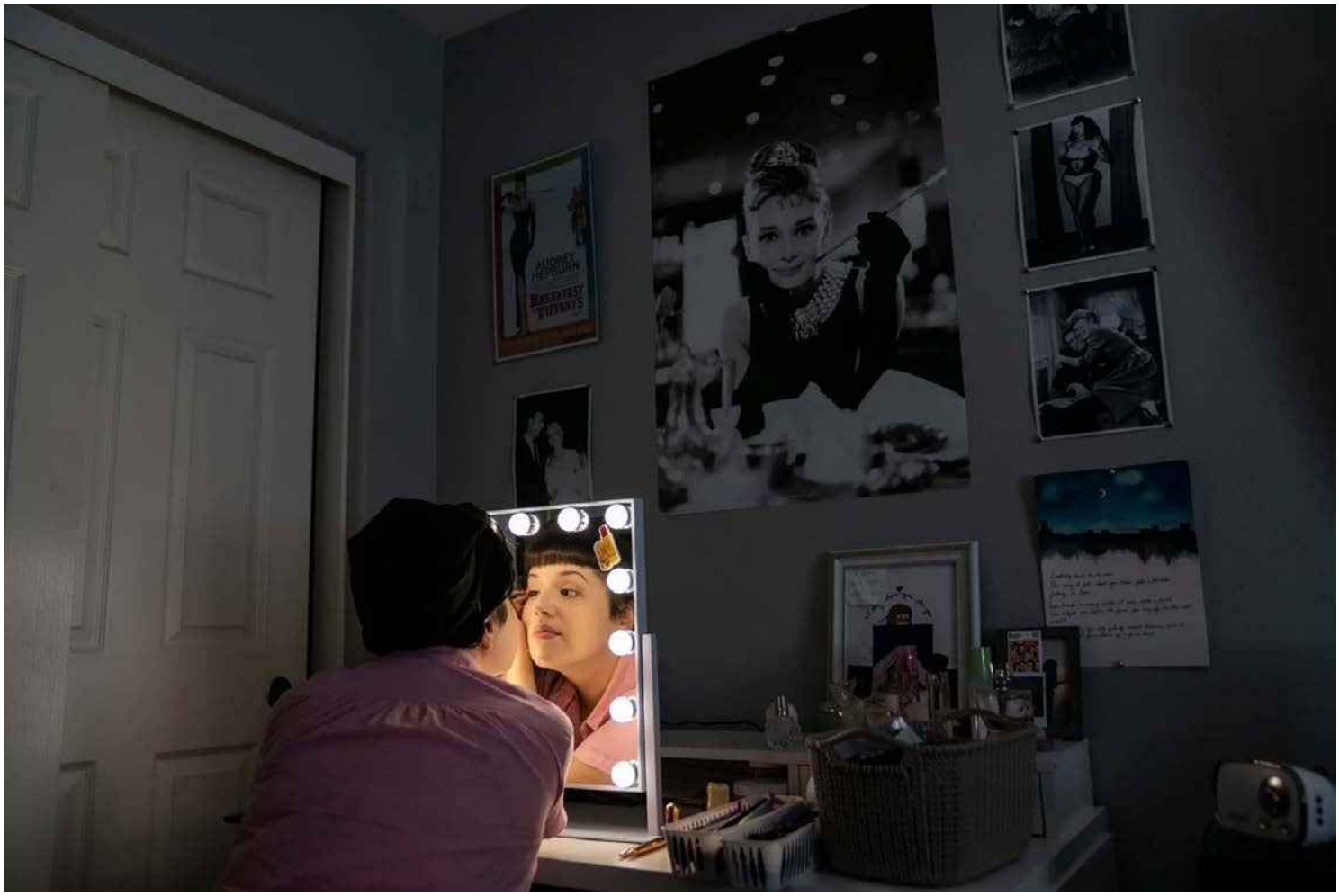
The drugs suppress estrogen and testosterone, hormones that help develop the reproductive system but also affect the bones, the brain and other parts of the body.

During puberty, bone mass typically surges, determining a lifetime of bone health. When adolescents are using blockers, bone density growth flatlines, on average, according to an analysis commissioned by The Times of observational studies examining the effects.



Jacy Chavira, 22, thinks puberty blockers were prescribed to her too quickly. After treatment with blockers starting at 13, followed by testosterone, she has resumed her female identity. Verónica G. Cárdenas for The New York Times

Many doctors treating trans patients believe they will recover that loss when they go off blockers. But two studies from the analysis that tracked trans patients' bone strength while using blockers and through the first years of sex hormone treatment found that many do not fully rebound and lag behind their peers.

That could lead to heightened risk of debilitating fractures earlier than would be expected from normal aging — in their 50s instead of 60s — and more immediate harm for patients who start treatment with already weak bones, experts say.

"There's going to be a price," said Dr. Sundeep Khosla, who leads a bone research lab at the Mayo Clinic. "And the price is probably going to be some deficit in skeletal mass."

Many physicians in the United States and elsewhere are prescribing blockers to patients at the first stage of puberty — as early as age 8 — and allowing them to progress to sex hormones as soon as 12 or 13. Starting treatment at young ages, they believe, helps patients become better aligned physically with their gender identity and helps protect their bones.

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But that could force life-altering choices, other doctors warn, before patients know who they really are. Puberty can help clarify gender, the doctors say — for some adolescents reinforcing their sex at birth, and for others confirming that they are transgender.

"The most difficult question is whether puberty blockers do indeed provide valuable time for children and young people to consider their options, or whether they effectively 'lock in' children and young people to a treatment pathway," wrote Dr. Hilary Cass, a pediatrician leading an independent review in England of medical treatments of adolescents presenting as transgender.

"There's going to be a price," said Dr. Sundeep Khosla, who leads a bone research lab at the Mayo Clinic. "And the price is probably going to be some deficit in skeletal mass." Jenn Ackerman for The New York Times

On her recommendation, England's National Health Service last month proposed restricting use of the drugs for trans youths to research settings. Sweden and Finland have also placed limits on the treatment, concerned not just with the risk of blockers, but the steep rise in young patients, the psychiatric issues that many exhibit, and the extent to which their mental health should be assessed before treatment.

In the United States, though, there is no universal policy, and the public discussion is polarized.

Republican governors and lawmakers in more than a dozen states are working to limit or even criminalize the treatments, as some in their party also seek to restrict access to sports and bathrooms, ban discussion of gender in public schools, and call into question whether transgender identity even exists. (This month, the Florida medical board banned medications and surgeries for new patients under 18.) Meanwhile, the Biden administration describes transgender medicine as a civil right. And some advocates criticize anyone who questions the treatments' safety.

Long-awaited research funded by the National Institutes of Health could provide more guidance. In 2015, four prominent American gender clinics were awarded $7 million to examine the effects of blockers and hormone treatment on transgender youth. In explaining their study, the researchers pointed out that the United States had produced no data on the impact or safety of blockers, particularly among transgender patients under 12, leaving a "gap in evidence for this practice." Seven years in, they have yet to report key outcomes of their work, but say the findings are coming soon.

Many young patients and their families have concluded that the benefits of easing the despair of gender dysphoria far outweigh the risks of taking blockers. For others, the limited studies and politicization of trans medicine can make it difficult to fully evaluate the decision. A Reuters examination of a range of transgender treatments also found scant research into the long-term effects.

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Three years after starting the drugs, Emma Basques believes she's on the right path.

Jacy Chavira, now 22, decided that the medical treatment was not appropriate for her and resumed her female identity.

And the New York adolescent had such a significant loss in bone density after more than two years on blockers that the parents halted use of the drugs.

"We went into this because we wanted to help," the mother said. "Now I worry that we got into a situation with a very powerful drug and don't understand what the long-term effects will be."

Emma's mother, Cherise Basques, right, and father let her grow her hair longer and take other steps to socially transition when she was 5. Verónica G. Cárdenas for The New York Times

'Time to Start'

It didn't take long for Cherise and Arick Basques to realize that their toddler was different. The child rejected pants, toy trucks and sports in favor of dresses, Barbie dolls and ballet. When Ms. Basques ran into a friend at a restaurant in their Phoenix suburb and introduced her then-4-year-old as her son, the child shouted: "No! I'm your daughter!"

The couple worked with children — Ms. Basques as an occupational therapist, her husband as a teacher and school administrator — but this was unfamiliar territory. None of the therapists the parents called felt equipped to help. Their pediatrician offered only that things could change once the child started school, Ms. Basques said. Eventually, the couple discovered a local support group for parents of transgender children.

The next year, they allowed the child, then 5, to begin using the name Emma, grow longer hair and take other steps to socially transition. In 2019, when Emma turned 11, a physician at a local gender clinic advised starting blockers.

"At the first subtle signs of puberty, it was like: 'Yep, that's it. Time to start!'" recalled Ms. Basques. Along with her husband and Emma, she asked that their full names be used because they consider themselves advocates of the treatment.

For decades, transgender medical treatment in multiple countries was restricted to patients 18 and older. But in the 1990s, a hospital clinic in Amsterdam began treating adolescents.

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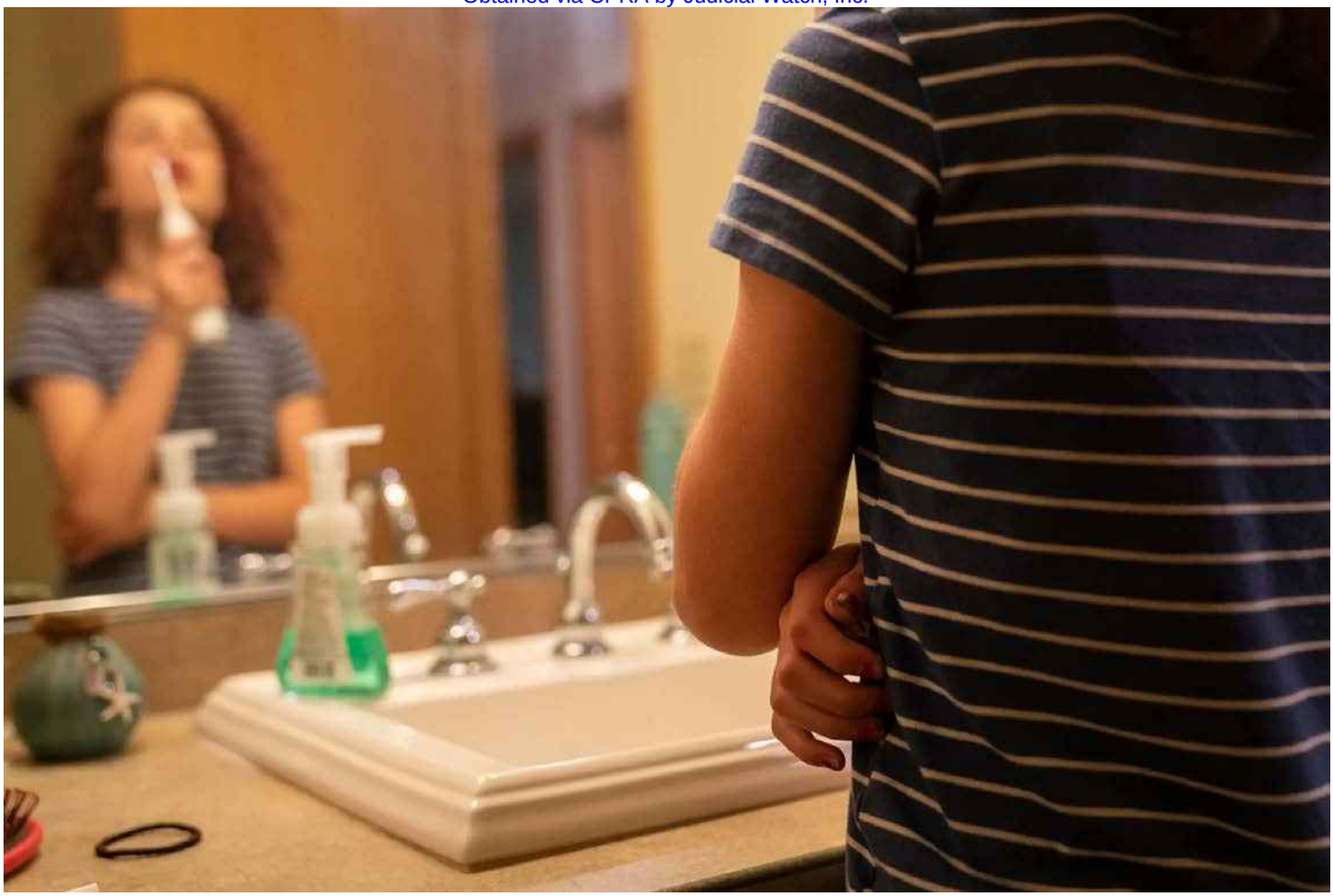

By the time Emma began taking blockers, in 2019, multiple medical groups had endorsed their use for gender dysphoria. Verónica G. Cárdenas for The New York Times

Puberty blockers can be given as an injection or an implant. (The best known is Lupron, made by AbbVie.) They were being used in the United States and elsewhere, with approval by the F.D.A. and its counterparts overseas, to treat prostate cancer; endometriosis, a painful disease that causes uterine tissue to grow elsewhere in the body; and the unusually early onset of puberty, typically age 6 or 7. If blockers were safe for patients with that rare condition, known as central precocious puberty, the Dutch doctors reasoned, they were likely to be safe for trans adolescents too.

The first trans patient treated with blockers, from age 13 to 18, moved on to testosterone, the male sex hormone. Halting female puberty had offered emotional relief and helped him look more masculine. As the Dutch clinicians prescribed blockers, followed by hormones, to a half-dozen other patients in those early years, the medical team found that their mental health and well-being improved.

“They were usually coming in very miserable, feeling like an outsider in school, depressed or anxious,” recalled Dr. Peggy Cohen-Kettenis, a retired psychologist at the clinic. “And then you start to do this treatment, and a few years later, you see them blossoming.”

In 1998, she worked with a small international group — which would later expand and become known as the World Professional Association for Transgender Health, or WPATH — to include puberty blockers and hormones for adolescents in their treatment guidelines.

The Dutch doctors had yet to publish any research findings, she acknowledged. Some other physicians, including the one overseeing transgender medical treatment in England, were wary of potential harm.

But doctors in the group considered the early results from Amsterdam as reassuring enough to move forward. They were eager to treat the psychological distress observed in many trans adolescents.

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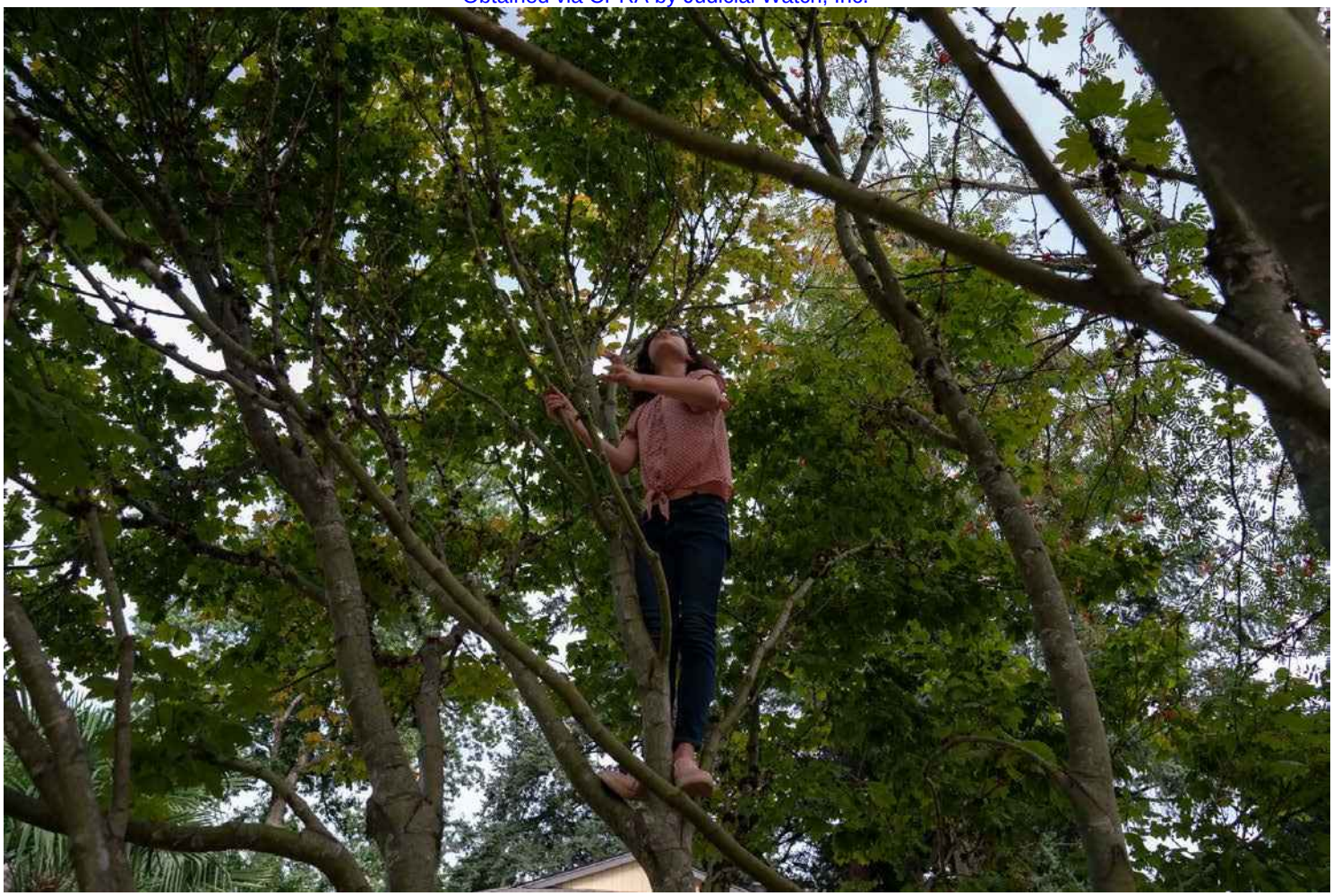

"It was just really exciting," Emma said of starting her transition. "I finally got to be who I was." Verónica G. Cárdenas for The New York Times

Doctors debated about whether "starting the puberty blockers would somehow damage the children," recalled Dr. Walter Meyer, a Texas pediatric endocrinologist and psychiatrist involved with the 1998 standards of care.

"The Dutch were saying, 'Oh, no, it's not causing a problem,'" said Dr. Meyer, who continues to support the use of the drugs.

Dr. Cohen-Kettenis hoped physicians in other countries would adopt the Dutch protocol, and document and share the outcomes as she and her colleagues in Amsterdam planned. Her clinic treated only patients who had consistently presented as transgender since early childhood and did not suffer from distinct psychiatric disorders that could interfere with diagnosis or treatment. They had to be at least 12 for puberty blockers, with the option of moving on to hormones at 16.

The international standards of care advised similar criteria. But they were recommendations, not requirements. Soon, the use of puberty blockers spread. In the United States and Canada, countries without centralized health systems, protocols were largely left to the discretion of individual clinics and practitioners. Dr. Spack, the pediatric endocrinologist who led U.S. adoption of the treatment, opened the first American clinic in 2007 at Boston Children's Hospital; others eventually followed in nearly every state.

Some started children on blockers at the first signs of puberty and prescribed testosterone or estrogen to patients 14 or younger. Doctors believed that earlier treatment would lead to more successful medical transitions, and wanted to spare patients the difficulty of watching their peers develop while their own bodies remained unchanged.

The doctor in Arizona who treated Emma, for example, tells preteen patients that if he prescribed blockers and didn't start hormones for five years, they would look 12 at age 16.

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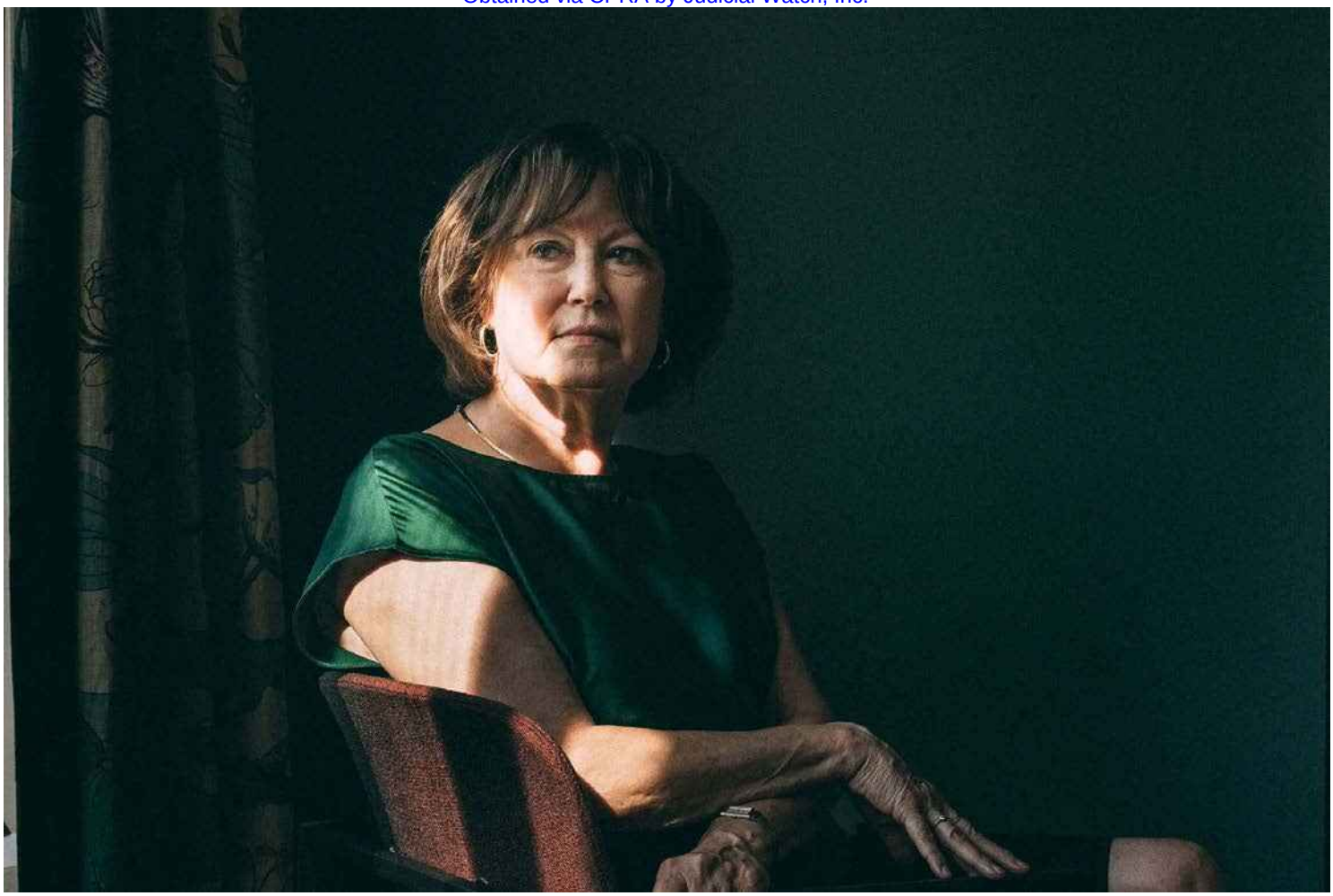

Dr. Peggy Cohen-Kettenis was a psychologist in the Dutch clinic that pioneered treatments for transgender youths. “They were usually coming in very miserable,” she recalled. With treatment, she said, “you see them blossoming.” Marlena Waldthausen for The New York Times

Transgender activists across the country pushed for early and easy access to the treatment. At a 2006 Philadelphia medical convention, Jenn Burleton, an advocate from Oregon, heard Dr. Spack describe his experience starting to treat adolescents with blockers. Like others of her generation, Ms. Burleton, now 68, could not medically transition until adulthood, and puberty had been traumatic. Treating adolescents with blockers was “game-changing,” she said.

Back home, Ms. Burleton prodded pediatric endocrinologists to adopt the practice for their patients. “We have a chance to prevent them from being emotionally broken,” she recalled saying.

Advocates successfully pushed Oregon, Massachusetts, California and other states to allow for Medicaid coverage of puberty blockers for adolescents identifying as trans. They also helped win approval in Oregon for a variety of medical workers — doctors, nurse practitioners, naturopaths — to administer blockers if overseen, even long-distance, by an endocrinologist.

“It went so quickly that not even centers but individual clinicians, people who were not knowledgeable, were just giving this kind of treatment,” said Dr. Cohen-Kettenis, the Dutch psychologist. “There was a great concern.”

By the time Emma Basques began taking blockers in 2019, multiple medical groups had endorsed their use for gender dysphoria. Among them were the American Academy of Pediatrics and the international Endocrine Society, which in 2017 had described the limited research on the effects of the drugs on trans youth as “low-quality.” Still, the organizations were encouraged by what they saw as a promising treatment.

Many doctors point out that it’s not unusual for research to lag behind the launch of new treatments and for drugs to be used off-label on patients without F.D.A. approval, especially in pediatric medicine.

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Jenn Burleton, an advocate from Oregon, speaking at a support group for parents whose children identify as transgender. Verónica G. Cárdenas for The New York Times

An F.D.A. spokeswoman said in a statement that doctors have the discretion to do so, but also noted that just because a drug has been approved for one class of patients doesn't mean it's safe for another.

There is no centralized tracking of blocker prescriptions in the United States. Komodo Health, a health technology company, compiled private and public insurance data for Reuters, showing a sharp increase in the number of children ages 6 to 17 diagnosed with gender dysphoria, from about 15,000 in 2017 to about 42,000 in 2021. During that time, 4,780 patients with that diagnosis were put on puberty blockers covered by insurance, the data shows, with new prescriptions growing each year. But the data does not capture the many cases in which insurance does not cover the drugs for that use, leaving families to pay out of pocket.

Some leading American practitioners asked AbbVie and Endo Pharmaceuticals, maker of another blocker, to seek F.D.A. approval for the drugs' use among trans adolescents. The drugmakers would have to fund research for a patient population that made up just a small part of their market. But the physicians argued that regulatory approval could help establish the safety of the treatment and broaden insurance coverage of the drugs, which can cost tens of thousands of dollars a year. In the end, AbbVie and Endo said no. The companies declined to comment on the decision.

Emma Basques was on blockers for two years. Then, after she turned 13 in October of last year, a doctor in the Portland, Ore., suburb where her family had moved, prescribed estrogen, starting her transition. It had become increasingly awkward to feel left behind as her classmates physically matured. And she felt confident that she was ready.

"It was just really exciting," Emma said. "I finally got to be who I was."

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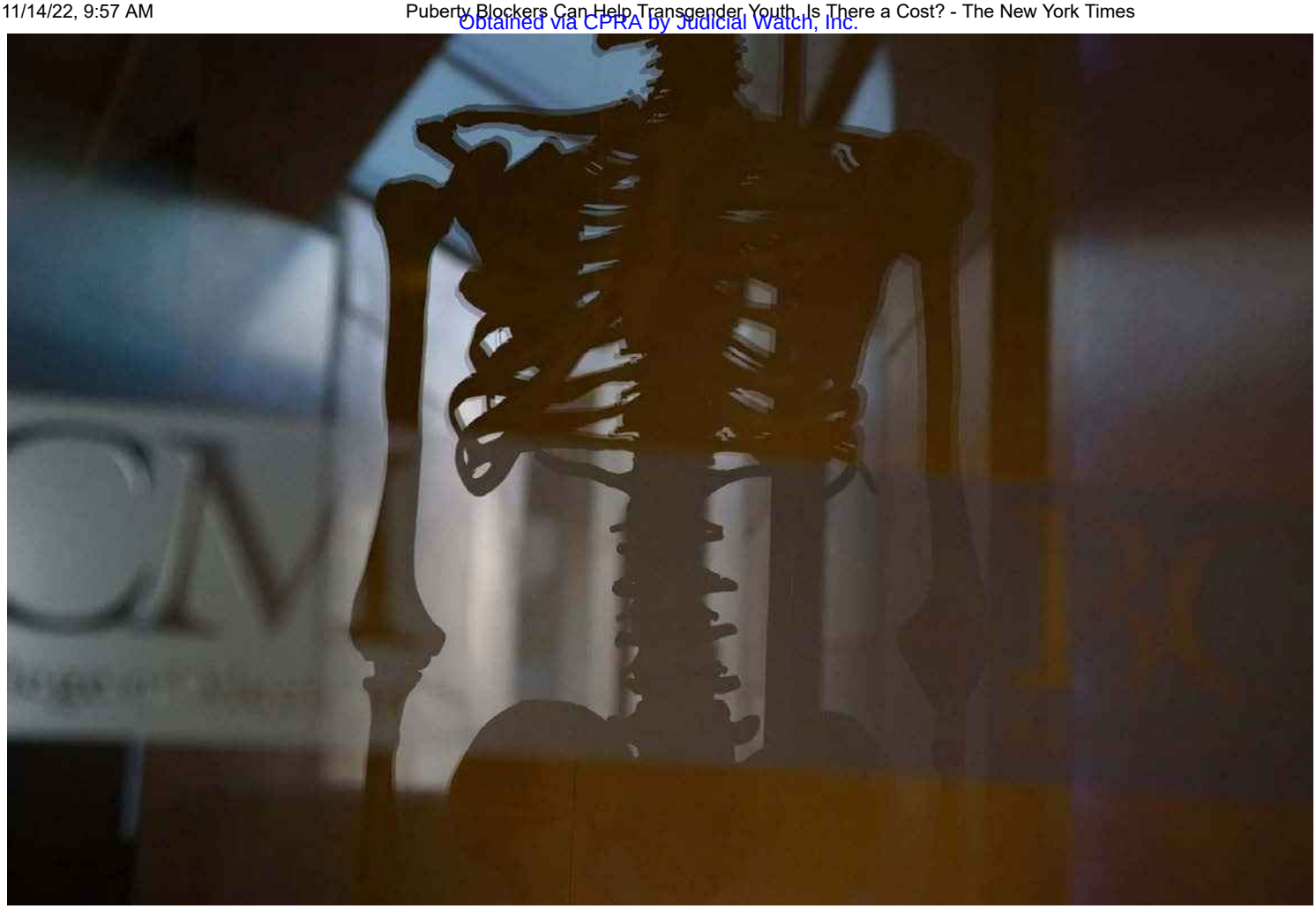

A skeleton model at the Baylor College of Medicine in Houston. A full accounting of blockers' risk to bones is not possible. Because most treatment is provided outside of research studies, there's little public documentation of outcomes. Callaghan O'Hare for The New York Times

'We Need to Give This a Chance'

The 11-year-old in New York, who had begun puberty and started at a new school, was increasingly distressed — refusing to bathe or go to class and, for the first time, expressing a desire to no longer have a girl's body.

When the parents consented to blockers in 2018, they hoped the drug would bring emotional stability and time to consider next steps.

"If everyone thinks this will help, and it's reversible, then we need to give this a chance," said the mother, who asked that her name be withheld to protect the family's privacy.

The first two years were promising, with the patient, by then a teen, taking Prozac in addition to the blockers. But at the start of the third year, a bone scan was alarming. During treatment, the teen's bone density plummeted — as much as 15 percent in some bones — from average levels to the range of osteoporosis, a condition of weakened bones more common in older adults.

The doctor recommended starting testosterone, explaining that it would help the teen regain bone strength. But the parents had lost faith in the medical counsel.

"I was furious," the mother recalled. "I'm thinking, 'I worry we've done permanent damage.'"

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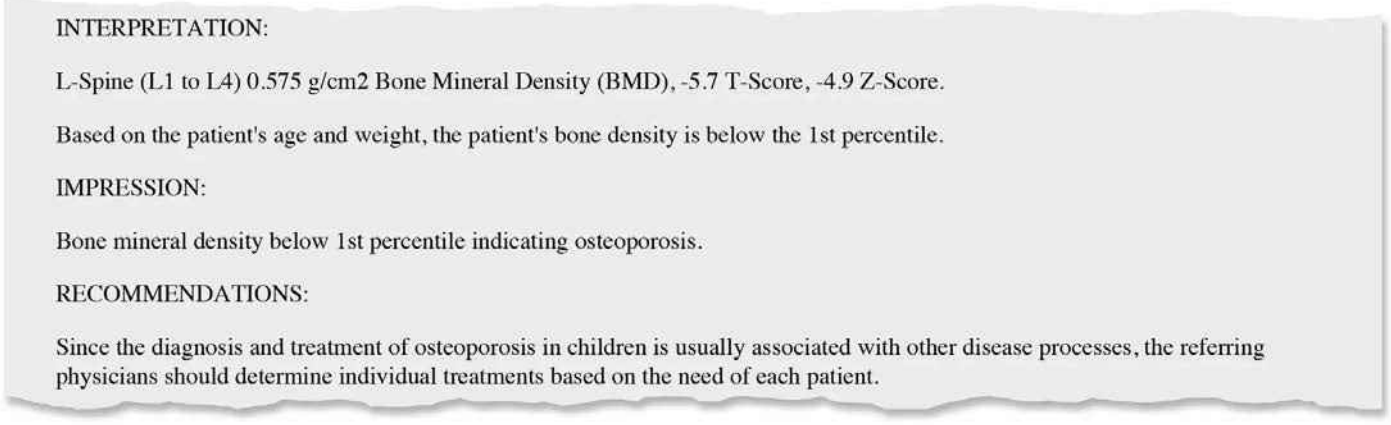

INTERPRETATION:

L-Spine (L1 to L4) 0.575 g/cm2 Bone Mineral Density (BMD), -5.7 T-Score, -4.9 Z-Score.

Based on the patient's age and weight, the patient's bone density is below the 1st percentile.

IMPRESSION:

Bone mineral density below 1st percentile indicating osteoporosis.

RECOMMENDATIONS:

Since the diagnosis and treatment of osteoporosis in children is usually associated with other disease processes, the referring physicians should determine individual treatments based on the need of each patient.

A Texas teenager had very low bone density in the lumbar spine after a year on blockers, records show. No baseline bone scan had been performed at the outset of treatment. The New York Times

A full accounting of blockers' risk to bones is not possible. While the Endocrine Society recommends baseline bone scans and then repeat scans every one to two years for trans youths, WPATH and the American Academy of Pediatrics provide little guidance about whether to do so. Some doctors require regular scans and recommend calcium and exercise to help to protect bones; others do not. Because most treatment is provided outside of research studies, there's little public documentation of outcomes.

But it's increasingly clear that the drugs are associated with deficits in bone development. During the teen years, bone density typically surges by about 8 to 12 percent a year. The analysis commissioned by The Times examined seven studies from the Netherlands, Canada and England involving about 500 transgender teens from 1998 through 2021. Researchers observed that while on blockers, the teens did not gain any bone density, on average — and lost significant ground compared to their peers, according to the analysis by Farid Foroutan, an expert on health research methods at McMaster University in Canada.

The findings match what practitioners of the treatment have seen, including Dr. Catherine Gordon, a pediatric endocrinologist and bone researcher at Baylor College of Medicine in Houston. "When they lose bone density, they're really getting behind," said Dr. Gordon, who is leading a separate study on why the drugs have such an effect.

Many doctors caring for young trans patients are reassured by the rebounds seen in the children who take blockers for unusually early puberty. In most cases, their bone strength fully recovers after they stop the drugs at about age 11 and resume full puberty, which can last up to five years. But patients identifying as trans take the drugs later, interrupting their normally timed puberty and limiting that crucial period of development.

"That's the difference," Dr. Gordon said. "You shorten that critical window of puberty."

So far, only two small studies, published by Dutch doctors, have tracked the bone development of trans patients from beginning blockers through early hormone treatment. In both studies, dozens of patients started blockers at 14 or 15, on average, and began estrogen or testosterone at 16. The participants, followed in one study through age 18, and in the other through age 22, saw their bones strengthen, on average, once on hormones. Still, most patients continued to lag behind their peers; trans men neared average levels, but trans women fell far below.

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Dr. Catherine Gordon, a pediatric endocrinologist and bone researcher at Baylor, is leading a study on the effects of puberty blockers on bone development in transgender youths. Callaghan O'Hare for The New York Times

"I think there's a false sense of security," said Dr. Khosla, the Mayo Clinic specialist, who is skeptical that all trans patients can catch up.

Dr. Khosla and Dr. Gordon don't believe the effects on bones are reason for medical providers to halt use of the drugs in adolescents. But they think the risks should be factored into patient decisions and that bones should be carefully monitored.

If any harm resulted from the use of blockers, it likely would not be evident until decades later, with fractures. However, for children who already have weak bones as they start treatment, the dangers could be more immediate. While there is no systematic record-keeping of such cases, some anecdotal evidence is available.

After more than a year on blockers, a 15-year-old in Texas, who had not had a baseline scan, showed spinal bone density so low that it was below the first percentile for the teen's age and weight, indicating osteoporosis, according to medical records from earlier this year.

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Emma takes calcium, makes an effort to exercise and has undergone scans showing that her bones are healthy. Verónica G. Cárdenas for The New York Times

A transgender adolescent in Sweden who took the drugs from age 11 to 14 with no bone scans until the last year of treatment developed osteoporosis and sustained a compression fracture in his spine, an X-ray showed in 2021, as reported earlier in a documentary on Swedish television.

“The patient now suffers from continued back pain,” medical records note, describing a “permanent disability” caused by the blockers.

Some practitioners in the United States and Australia do not provide the drugs to patients who are well into puberty, concerned that the treatment poses the greatest threat to bones in that period.

“You’re potentially taking on risks that I felt should be avoided,” said Dr. Stephen Rosenthal, medical director of the University of California, San Francisco, Child and Adolescent Gender Center.

He won’t prescribe blockers as a stand-alone treatment to anyone over 14. That includes the growing number of nonbinary youths who don’t want to mature into either male or female bodies. “We make it very clear that no one stays on a blocker,” he said.

Dr. Rosenthal is a principal investigator in the yearslong N.I.H. study, which also involves gender clinics in Los Angeles, Chicago and Boston. Asked why they have yet to report on key outcomes, he said their research was delayed when the pandemic halted in-person treatment. Papers on the effects of blockers on bones and other findings should be published next year, he said.

Like many physicians, Dr. Rosenthal believes the benefits of using blockers to alleviate gender dysphoria are much greater than any risks to bones. (He was among the doctors who filed statements in a lawsuit against an Alabama ban on medical treatment of trans youth.)

Emma Basques, for example, takes calcium, makes an effort to exercise and has undergone scans that showed her bones are healthy. “I can’t even imagine how life would be for Emma,” said her mother, Ms. Basques, “if she was not given blockers and had to go through male puberty.”

Emma added: “I wouldn’t like my body at all.”

But the parents in New York insisted on ending treatment for their teen, who has yet to have a follow-up scan to see if bone density has improved since going off blockers.

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"I don't think we have the science behind them to be prescribing these drugs," the mother said.

"I wish I hadn't been steered into transitioning the way I was, and that I had been told there were other ways to cope with the discomfort of puberty," Ms. Chavira said. Verónica G. Cárdenas for The New York Times

'I Wish There Had Been More Questions'

Jacy Chavira, in Southern California, had already cut her hair short and begun binding her chest when she was prescribed blockers at age 13. A therapist and her parents agreed that gender dysphoria, a condition Jacy learned about from a magazine, could explain the mounting anxiety and discomfort that she was experiencing during early puberty.

Once on blockers, Ms. Chavira said, she became fixated on moving ahead with a medical transition. She was thrilled shortly after turning 16 when her pediatric endocrinologist prescribed testosterone. But soon she started having doubts. Her body was growing more masculine, but she was secretly putting on dresses. At 17, in a consultation for breast removal, she worried aloud about the potential loss of feeling in the nipples. To her, this was a sign of not wanting to go through with the surgery.

She came to realize that her anguish had stemmed from a larger inner conflict, and that continuing with a gender transition would be a mistake. "I believe it was an issue with my identity, accepting who I was, and not just the physical female portion of it," she said.

Like Ms. Chavira, most patients who take puberty blockers move on to hormones to transition, as many as 98 percent in British and Dutch studies. While many doctors see that as evidence that the right adolescents are getting the drugs, others worry that some young people are being swept into medical interventions too soon.

Over the past decade, growing numbers of medical providers have lowered the ages at which they prescribe the treatments. Today, the WPATH and Endocrine Society advise that blockers can be prescribed at the first signs of puberty and hormone treatment, in some cases, earlier than 16. The American Academy of Pediatrics says blockers can be provided anytime during puberty and hormones from "early adolescence onward."

Some doctors and researchers are concerned that puberty blockers may somehow disrupt a formative period of mental growth. With adolescence comes critical thinking, more sophisticated self-reflection and other significant leaps in brain development. Sex hormones have been shown to affect social and problem-solving skills. It's believed that brain growth is connected to gender identity, but research in

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these areas is still very new.

Jacy at age 14, while on blockers. “I believe it was an issue with my identity,” she said, “accepting who I was, and not just the physical female portion of it.” Verónica G. Cárdenas for The New York Times

In a 2020 paper, 31 psychologists, neuroscientists and hormone experts from around the world urged more study of the effects of blockers on the brain.

“If the brain is expecting to receive those hormones at a certain time and doesn’t, what happens?” said Dr. Sheri Berenbaum, head of a gender research lab at Penn State, and one of the authors of the paper. “We don’t know.”

The physicians in the Amsterdam clinic, where the treatment began, have lowered their minimum ages for starting blockers and hormones. But they are very cautious in selecting patients.

“Our concern is always: When is gender identity fixed or not fluid anymore? And when do you fully understand the lifelong consequences of such treatment?” said Dr. Annelou de Vries, head therapist at the clinic.

For some medical professionals across the country, there are too many uncertainties about the effects of blockers to provide the treatment.

Among them are seven pediatric endocrinologists and pediatric endocrine nurse practitioners in Florida who recently wrote to the state health department that evidence to support the use of those treatments in adolescents “is simply lacking” and asking that it be confined to research settings.

“Without much data, it’s hard to make a conclusion that we’re doing the right thing,” said Dr. Matthew Benson, an assistant professor of pediatrics at Mayo Clinic College of Medicine in Jacksonville and an author of the letter. (He also voiced concerns at a state hearing in July on whether to stop allowing Medicaid coverage in Florida for transgender medical treatment.)

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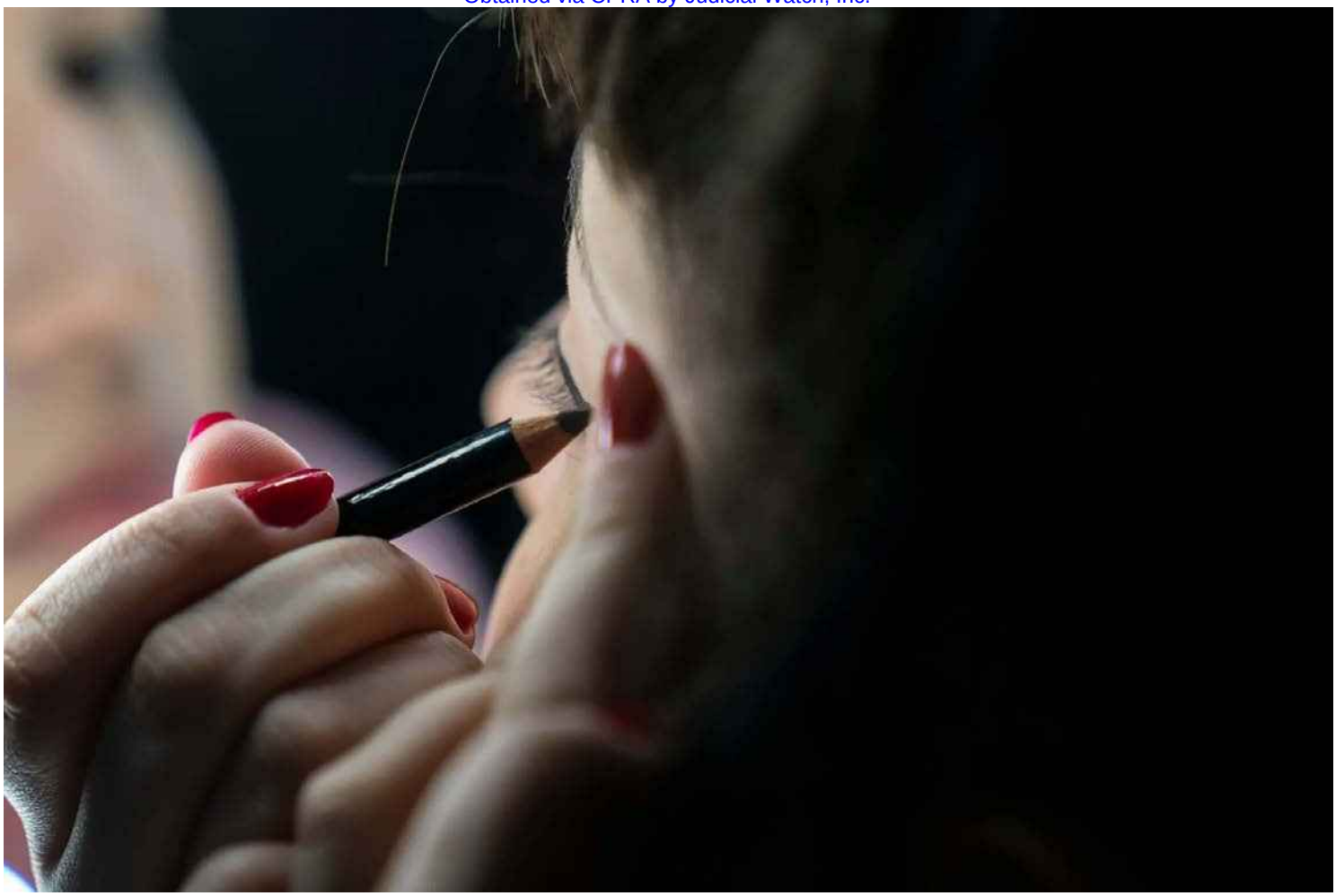

Ms. Chavira halted her medical treatment at 18, but she is left with a voice that sounds like a man's and other enduring physical changes. Verónica G. Cárdenas for The New York Times

Even enthusiasts, like Emma and her parents, acknowledge it can be hard to fully grasp all the potential results of treatment. Infertility is among other lasting effects for patients who start blockers at the first stage of puberty and proceed to hormones and surgery. Emma was advised that, to possibly preserve fertility, she would need to pause treatment at some point down the line, with the hopes of developing and freezing sperm.

"I knew what I wanted," Emma said of her medical transition. "But all this other stuff was kind of just confusing." Her father said, "We worked really hard to talk to her at her age level to make sure she understood some of these more complicated things."

When Dutch doctors launched the use of blockers and hormones on trans youth decades ago, they warned in their early papers of the possibility of "false positives" — patients who medically transition, then later declare they are not transgender.

There's no official tracking of those cases and many practitioners believe the total numbers are small. So far, scores of accounts have emerged in social media, news stories and published research.

Keira Bell, who was prescribed blockers at age 16, then moved on to testosterone and breast-removal surgery, no longer identified as transgender five years after starting to transition. She sued the Tavistock gender clinic in London where she had been treated. (A judge ruled that patients under 16 were unable to consent to puberty blockers — a decision later overturned on appeal.)

Jacy Chavira, looking back on her own experience, thinks that drugs were prescribed too quickly. At 18, she halted her medical treatment and resumed her female identity. Now, she is left with a voice that sounds like a man's and other enduring physical changes.

"I wish there had been more questions asked by the doctors," she said. "I wish I hadn't been steered into transitioning the way I was, and that I had been told there were other ways to cope with the discomfort of puberty."

Alarmed by the uncertain number of cases like Jacy's, as well as the rising numbers of patients with gender dysphoria and the psychiatric disorders many display, Sweden is working to standardize adolescent transgender medical treatment and restrict it to research settings.

Finland is also limiting treatment, more closely following the Dutch protocol, and doctors there remain concerned about the physical effects of blockers, including on brain development, said Dr. Riittakerttu Kaltiala, chief of adolescent psychiatry at a gender clinic in Tampere. (Dr. Kaltiala testified this fall before the Florida medical board as it was considering its ban on treatment.)

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As European countries continue to examine and tailor their treatment, in the United States the public discourse about transgender care is growing more incendiary.

Last month, the American Academy of Pediatrics and other medical groups wrote to Attorney General Merrick B. Garland, urging the Justice Department to investigate growing threats of violence against physicians and hospitals that provide transgender medical treatment to adolescents. As more Republicans frame the treatment as child abuse, some doctors have become wary of discussing their work for fear of becoming targets.

More than a dozen doctors declined to be interviewed for this article, and several who spoke to The Times — some who support treatment, others who question it — asked not to be named.

The climate could have a chilling effect on research, said Dr. Natalie Nokoff, assistant professor of pediatric endocrinology at the University of Colorado, who recently conducted a soon-to-be-published study showing that a longer treatment period on puberty blockers was associated with a lower bone density.

“It’s leading to concerns that people’s well-intentioned scientific research could be misconstrued” and exploited for political gain, she said.

The prospect of such an outcome is disheartening for the families of Emma Basques, Ms. Chavira and the teen in New York. Despite their differing experiences, they share the same hopes for transgender medicine: less vitriol, more science.

Methodology

The analysis commissioned by The Times examined the findings of seven observational studies from the Netherlands, England and Canada, documenting the association between puberty blockers and bone density in about 500 adolescents.

In each study, bone density was measured at the spine and the hip using Dual-energy X-ray absorptiometry, or DEXA scan. The analysis looked at group means, because not every study released individual person data. Each study’s findings were weighted based on its number of participants.

The change in bone density while adolescents were on blockers was observed to be zero. The analysis also showed that the adolescents’ Z-scores, a measure of bone density that is benchmarked to peers, consistently fell during treatment with blockers.

The studies included are:

“Bone Mass in Young Adulthood Following Gonadotropin-Releasing Hormone Analog Treatment and Cross-Sex Hormone Treatment in Adolescents With Gender Dysphoria,” Klink et. al, Journal of Clinical Endocrinology & Metabolism, 2015

“Effect of Pubertal Suppression and Cross-Sex Hormone Therapy on Bone Turnover Markers and Bone Mineral Apparent Density (BMAD) in Transgender Adolescents,” Vlot et. al, Bone, 2017

“The Effect of GnRH Analogue Treatment on Bone Mineral Density in Young Adolescents With Gender Dysphoria: Findings From a Large National Cohort,” Joseph et. al, Journal of Pediatric Endocrinology and Metabolism, 2019

“Physical Changes, Laboratory Parameters and Bone Mineral Density During Testosterone Treatment in Adolescents With Gender Dysphoria,” Stoffers et. al, The Journal of Sexual Medicine, 2019

“Bone Development in Transgender Adolescents Treated With GnRH Analogues and Subsequent Gender-Affirming Hormones,” Schagen et. al, Journal of Clinical Endocrinology & Metabolism, 2020

“Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12- to 15-Year-Old Young People With Persistent Gender Dysphoria in the U.K.,” Carmichael et. al, PLOS One, 2021

“Pubertal Suppression, Bone Mass and Body Composition in Youth With Gender Dysphoria,” Navabi et. al, Pediatrics, 2021

Julie Tate contributed research.

Megan Twohey is a prize-winning investigative reporter and a best-selling author who has focused much of her work on the treatment of women and children. @mega2e • Facebook

Christina Jewett covers the Food and Drug Administration. She is an award-winning investigative journalist and has a strong interest in how the work of the F.D.A. affects the people who use regulated products. @By_Cjewett

A version of this article appears in print on , Section A, Page 1 of the New York edition with the headline: Pressing Pause on Puberty

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Sunday, November 27, 2022 12:31 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@scdi.org.vn>
CC: [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

I would love to be able to meet, but I'm on vacation and away January 8th through 8th. I will be back on the 9th, but that may be too late for a visit since [redacted], you all be completing your U.S. visit on January 11th.

Best,
[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 24, 2022 11:09 AM
To: [redacted]@scdi.org.vn>
Cc: [redacted] <[redacted]@ucsf.edu>; [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

Dear [redacted],

It's very nice to hear from you! I apologize for my delayed response—just a very busy time. I would be able to meet with you during the day on Tuesday, January 3rd, starting at 1 PM. Our full Child and Adolescent Gender Center team is not currently meeting in person because of the pandemic, but rather by telehealth. However, I have cc'd my colleague, Dr. [redacted], whom you met in Hanoi, who may also be available to meet on the afternoon of January 3rd. Please let me know if January 3rd at 1 PM works for you, and i can send you details of where we can meet. I have also cc'd Dr. [redacted], in the event that she is also able to meet at that time.

Best wishes,

Sincerely,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@scdi.org.vn>
Sent: Tuesday, November 15, 2022 6:30 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: SCDI - Visit trip for services providers and policy makers from Vietnam

This Message Is From an External Sender
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Dear Dr. Stephen,
I hope this email finds you well. I am writing to you to share that we are currently arranging a visit trip for a team of 5 people: 1 surgeon, 1 endocrinologist, 1 psychologist, 1 SCDI officer and 1 person on the drafting team to Los Angeles to visit Dr.

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[redacted] hospital, community people and policy makers there to learn about the cooperate between 3 services for transgender people. As you may know that we are advocating for the drafted law on gender affirmation and under the drafted law, the Ministry of Health need to develop 2 guidelines on surgery and psychological support but the drafting team don't have any ideas for this. They have learnt from other countries via documents we and our partners provided for them. We expect with this trip, they will have the opportunity to better understand this coordination as well as the support needed for transgender people. I know Los Angeles is a very good practice to learn but I wonder if we have time, may we visit you, your hospital and meeting with community organization, policy makers (if applicable) in San Francisco. The team will be in U.S from 2 - 11 January 2023 and we can have 3 days in San Francisco.
Thank you very much and I am looking forward to hearing from you.

Warm regards,

[redacted]

SCDI
Develop Together

[redacted] (Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
SCDI | Số 9 ngách 30 ngõ 165 Thái Hà, P.Láng Hạ, Q.Đống Đa | Hanoi | Vietnam
T +84 (0)24 3572 0679 (số máy lẻ: 161) | F +84 (0)4 3572 0689 | M [redacted]
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From: [redacted]@scdi.org.vn>
Sent: Sunday, November 27, 2022 7:41 PM PST
To: [redacted], [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

This Message Is From an Untrusted Sender
You have not previously corresponded with this sender.

Dear Dr. Stephen, Dr. [redacted] and Dr. [redacted],
Thank you very much for your kind support. Because of the visa submission requirement so all the team members have booked their round-trip flight (from Hanoi to LA and back) before I received your email. And I also understand that the pandemic situation is still serious in U.S. Therefore, could I suggest we have a zoom meeting in about 2 hours with Vietnam team member during their time in LA? if it is appropriate, I will share with you our detail agenda for this trip so we can arrange this meeting.

Thank you and warm regards,

[redacted]

SCDI
Develop Together

[redacted] (Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
SCDI | Số 9 ngách 30 ngõ 165 Thái Hà, P.Láng Hạ, Q.Đống Đa | Hanoi | Vietnam
T +84 (0)24 3572 0679 (số máy lẻ: 161) | F +84 (0)4 3572 0689 | M [redacted]
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From: [redacted] [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 28, 2022 3:31 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@scdi.org.vn>
Cc: [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

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Sincerely,

Steve

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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@scdi.org.vn>
Sent: Tuesday, November 15, 2022 6:30 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: SCDI - Visit trip for services providers and policy makers from Vietnam

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Dear Dr. Stephen,
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Warm regards,

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From: [redacted]@chla.usc.edu>
Sent: Monday, November 28, 2022 9:47 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: NIHMS1845428: Manuscript available in PMC

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Good morning,

Thank you for all of your responses! I greatly appreciate them!

Thanks,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 24, 2022 10:56 AM
To: [redacted]@chla.usc.edu>
Subject: Fw: NIHMS1845428: Manuscript available in PMC (EXTERNAL EMAIL)

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FYI

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

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San Francisco CA 94143-0434
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From:nihms-help@ncbi.nlm.nih.gov <nihms-help@ncbi.nlm.nih.gov>
Sent: Saturday, November 19, 2022 10:03 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: NIHMS1845428: Manuscript available in PMC

"Growth in transgender/gender-diverse youth in the first year of treatment with gonadotropin-releasing hormone agonists" (NIHMS1845428)

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The submission process for this manuscript is complete. As always, please feel free to contact us with any questions atnihms-help@ncbi.nlm.nih.gov.

Thank you,

The NIHMS Help Desk
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From: [redacted]@chla.usc.edu>
Sent: Monday, November 28, 2022 10:47 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: NIHMS1845428: Manuscript available in PMC

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 24, 2022 10:56 AM
To: [redacted]@chla.usc.edu>
Subject: Fw: NIHMS1845428: Manuscript available in PMC (EXTERNAL EMAIL)

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FYI

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From:nihms-help@ncbi.nlm.nih.gov <nihms-help@ncbi.nlm.nih.gov>
Sent: Saturday, November 19, 2022 10:03 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: NIHMS1845428: Manuscript available in PMC

"Growth in transgender/gender-diverse youth in the first year of treatment with gonadotropin-releasing hormone agonists" (NIHMS1845428)

Dear NIHMS Customer,

You are receiving this email because you are associated with the above-listed manuscript in the NIH Manuscript Submission (NIHMS) system. The manuscript is now available in PubMed Central (PMC) for public access in compliance with the funder's public access policy (see https://secure-web.cisco.com/1o8x-3ewVq5uDEli9WgAJC3zDPBmrWeNh1Pdwwz34RiYJ3XBXAiWH6h9nN19WyBdBVLVqRMWIlw7AqyxxzREXU2af7yqOGZSVbUMxqECK1R8FkeQCeRvPo1ql4FH534pT0JTLShxMuT4azIFVd01CeP2csSRYnmgHxIaseys7TV-uHn786cH7B3OLi9-b9aXX8Y7RP7Br1vsCG6grTeQvgh3s7_rqszZu2Nqyg40fli6ztiLs_4RtyzuMBw5hscLg2hautwIJ-KjjwNGkb8fJ3AZ-8XG0CrEprEI5URay1VU5hkHjZid7h2B9oqx6QNkihEmRliY5IIEPY8f91uOa2eaztbnDueZPaqgmJ3UdfkYCLJJndowkJ2vdejsxvOz31INEXAkDN9zM2VEp4Bvp2F3TeJ38_hP43Z_4jlrMJEdM4i265UWWZq0Fy_4laD3RgyGMSylQrGMrKq8Rysx8Dxiu96qk400GR1wQS):

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The NIHMS Help Desk
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From: [redacted]@ucsf.edu>
Sent: Monday, November 28, 2022 11:18 PM PST
To: [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi everyone,

My apologies for the delay in my reply... and thank you for your thoughtful responses!

We hear you loud and clear - having SW do an initial assessment seems very important! We trust you know what your patients & families need.

However, the feedback we have been hearing from [redacted] for a long time is that their job responsibilities had become unsustainable. Doing all the pre-clinic assessments, helping families get connected with qualified community mental health professionals, and providing general and crisis support to established families had become too heavy of a workload (and this was with the help of 2 MSW students and some time from [redacted] (.2 FTE)).

We would like to re-define the essential tasks of SW in the CAGC, to ensure that we are expecting a reasonable amount of work out of [redacted] during her 36 hour work-week.

Can we find a time to meet in the next week and discuss the role of SW in CAGC going forward?

I assume you all are busier than I am, so please let me know when it's a good time to meet. Generally, I'm available most times except for Mondays and Thursday mornings.

A million thanks! And we are really looking forward to talking this through with you all

[redacted]

[redacted] LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: [redacted] <[redacted].[redacted]@ucsf.edu>
Sent: Wednesday, November 23, 2022 12:32 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks, [redacted] for putting so much thought into this. I feel strongly that the social worker, not the scheduler, takes full responsibility for any pre-clinic contact with the family aside from the scheduling. The pre-clinic questionnaire and social work contact is actually the beginning of the gender care prior to the first visit and requires someone trained to take on this role. To date, the social work team has been invaluable in this regard.

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted].[redacted]@ucsf.edu

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From: [redacted]@ucsf.edu>
Sent: Wednesday, November 23, 2022 11:00 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Good morning everyone,

[redacted] and I had a productive meeting with [redacted] last week about how to use this transitional time to better streamline patients' entry into the CAGC clinic.

Our understanding of the current state is: [redacted] contacts all patients with new patient appointments in the upcoming month, and completes the following questionnaire over the phone. This information is then put into the chart for providers to have at the ready for the patient's first visit. Copy of the assessment is here:
CAGC First Visit Questionnaire (1).docx

Our proposal for changes to make: [redacted] will conduct a simplified version of the questionnaire with families over the phone when she calls to schedule them. A week before their appointment, she will do a reminder call & offer to have a Social Worker ([redacted]) contact them for any additional support needs. Additionally, if [redacted] identifies any potential complicating psychosocial factors during her phone conversations with families (ie unclear custody arrangement, patient with significant mental health concerns, transportation/insurance access issues, etc), [redacted] will send a referral to [redacted] via the Apex referral system for follow-up.

Curious to know a few things...

1. What are your initial thoughts/responses/concerns to this proposed change of workflow?
2. Is a SWer required to make contact with every patient, or is it permissible for it to be as-indicated?
3. Can this questionnaire be simplified at all?

Happy to sit and have a meeting about this if you'd prefer! Thanks again for your partnership.

[redacted] & [redacted]

[redacted], LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
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San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 4:23 PM
To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted],

The DPH grant is ending as of 11/30/22, so all CAGC Social Work support going forward will be from the Medical Center. I'm hoping you and [redacted] can soon resolve the total Social Work FTE.

Please keep me posted on the search for the new CAGC Social Worker position.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

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Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
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San Francisco CA 94143-0434
Pronouns: he/him/his

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Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 4:00 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: RE: CAGC SW

Hello,

I was also under the impression that we had 2x 0.9 positions, but recently heard differently and was told we have 1.6 total for CACG. I will continue to explore this further.
If we actually do have only 1.6, do we still have access to the .3 FTE from the DPH grant?

Also, we have hired for the 2nd position, [redacted], MSW is set to start on 11/7. We will send out a bio to the team soon.
I submitted an eRF to replace [redacted] and am waiting for this to be approved and posted.

Thank you,

[redacted] **LCSW**
Pediatric Social Work Manager
UCSF Benioff Children's Hospital, San Francisco

Pediatric Social Work Department
1975 4th Street, Box 4012 | San Francisco, CA 94158
Office: 415.514-7668
Email: [redacted]@ucsf.edu
Pronouns: she, hers, her, ella

UCSF Benioff Children's Hospitals

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 3:21 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi All,

I have cc'd [redacted] We (the CAGC) have had a 0.9 FTE Social Worker paid for by the Medical Center, and, as on 2/17/22 (see email from [redacted] below), we were awarded an additional 0.9 FTE Social Worker based on the needs of the CAGC. Therefore, we should have two Social Workers, each at 0.9 FTE for the CAGC ASAP --The funding for the 2nd Social Worker was approved 8 months ago!

I understand that we have a replacement for the position currently held by [redacted], who will be leaving UCSF as of 11/11/22.

Please let me know if the position for the 2nd Social Worker has been posted, and if not yet posted, please let me know when this is likely to happen. Again, the funding for the 2nd Social Worker was approved 8 months ago, so we really need to move forward with the hiring process.

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Thank you,

Steve

From: [redacted]@ucsf.edu>
Sent: Thursday, February 17, 2022 4:42 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC FTE Requests

All,

I have great news!

We received final approval on the 4.9 FTE investment request for CAGC. The positions are currently being posted by HR. Here's what was approved:

- 1.0 FTE Psychologist
- 1.0 FTE Practice Coordinator
- 0.9 FTE Social Worker
- 1.0 FTE LVN
- 1.0 FTE RN

I want to thank all of you for your patience as we worked to get this to the finish line. I also want to give kudos to [redacted] for her leadership in getting the request organized and building a compelling business case!

Thanks,

[redacted]

[redacted] MBA
Director
Children's Ambulatory Services
UCSF Health

Office: (415) 514-6388
Mobile: [redacted]

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 3:02 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: CAGC SW

Hi,

Please contact Steve and [redacted] regarding that information.

Thank you,

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Dr. [redacted], DNP, AC-PNP-BC
Nurse Practitioner
UCSF Pediatric Endocrinology

From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:18 AM
To: [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks [redacted].

Any info on where the funding from the other .9 FTE is from, if it's not also Medical Center?

Thanks,
[redacted]

[redacted], LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
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From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:17 AM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC SW

Here is the response on SW FTE:

2 x 0.9 FTE and one of those 0.9 FTE is from med center

[redacted], PNP
UCSF Pediatric Endocrinology
Assistant Clinical Professor
Department of Family Health Care
UCSF School of Nursing

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 29, 2022 9:05 AM PST
To: [redacted]@ucsf.edu>
Subject: Re: LGBTQ+ Collaborative Fall Meeting (open for agenda & Zoom info)

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]
Sent: Monday, November 28, 2022 8:17 AM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@mindspring.com <[redacted]@mindspring.com>; [redacted]@ucsf.edu>
Subject: LGBTQ+ Collaborative Fall Meeting (open for agenda & Zoom info)
When: Monday, December 5, 2022 9:00 AM-10:30 AM.
Where: https://ucsf.zoom.us/[redacted]

LGBTQIA+ Leadership & Advocacy Network
Fall 2022 Meeting, December 5th

Agenda:

- Round table of activities, initiatives, and updates from the group
- Department of Surgery has partnered with **The Association of Out Surgeons and Allies** (**AOSA**)
- ACTION ITEM – Steven Rosenthal and Adolescent gender clinic
- ACTION ITEM – meeting to get summary from Shane Snowden (from Sue)
- ACTION ITEM – Engage Suresh & his strategic plan, outside global DEIA.
- ACTION ITEM – read on equity work from Kevin Grumbach & Malcom John
- ACTION ITEM – invite CJ to these meetings
- ACTION ITEM – John: Columbia Univ. follow-up
- ACTION ITEM – Re-engage with UC Alumni as thought partners

[redacted](he/him/él) is inviting you to a scheduled Zoom meeting.

Topic: LGBTQ Collaborative Meeting
Time: This is a recurring meeting Meet anytime
Meeting ID: [redacted]
Password: [redacted]
Phone or Conference room password: [redacted]

One Click Join from a PC, Mac, Linux, iOS or Android device:
[redacted]

One tap mobile (iPhone)
[redacted]

Dial by your location
[redacted]

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Meeting ID: [redacted]
Password: [redacted]

Connecting from a room system:
IP: [redacted]
SIP: [redacted]
Meeting ID: [redacted]
Password: [redacted]

UCSF Zoom instance is approved for use with restricted data.

For more information on Zoom:
https://it.ucsf.edu/services/zoom-web-conferencing

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 29, 2022 9:22 AM PST
To: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted],

I think that you've made a clear and compelling argument for why having one social worker for the CAGC at 36 hours/week just doesn't cut it. It's my understanding that hiring a replacement for [redacted] at 0.6 FTE (24 hours/week) is in process. Do you think that additional FTE will enable the ability for SW to carry out the tasks that have been so valued in our interdisciplinary model of care?

I'm happy to participate in a meeting to further discuss CAGC SW. I have most flexibility on Friday afternoons, but will be away 12/1-12/11.

Thanks very much,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
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Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
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We hear you loud and clear - having SW do an initial assessment seems very important! We trust you know what your patients & families need.

However, the feedback we have been hearing from [redacted] for a long time is that their job responsibilities had become unsustainable. Doing all the pre-clinic assessments, helping families get connected with qualified community mental health professionals, and providing general and crisis support to established families had become too heavy of a workload (and this was with the help of 2 MSW students and some time from [redacted] (.2 FTE)).

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A million thanks! And we are really looking forward to talking this through with you all.

[redacted]

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[redacted] LCSW
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Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks, [redacted], for putting so much thought into this. I feel strongly that the social worker, not the scheduler, takes full responsibility for any pre-clinic contact with the family aside from the scheduling. The pre-clinic questionnaire and social work contact is actually the beginning of the gender care prior to the first visit and requires someone trained to take on this role. To date, the social work team has been invaluable in this regard.

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e-mail: [redacted]@ucsf.edu

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Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Good morning everyone,

[redacted] and I had a productive meeting with [redacted] last week about how to use this transitional time to better streamline patients' entry into the CAGC clinic.

Our understanding of the current state is: [redacted] contacts all patients with new patient appointments in the upcoming month, and completes the following questionnaire over the phone. This information is then put into the chart for providers to have at the ready for the patient's first visit. Copy of the assessment is here:
CAGC First Visit Questionnaire (1).docx

Our proposal for changes to make: [redacted] will conduct a simplified version of the questionnaire with families over the phone when she calls to schedule them. A week before their appointment, she will do a reminder call & offer to have a Social Worker ([redacted]) contact them for any additional support needs. Additionally, if [redacted] identifies any potential complicating psychosocial factors during her phone conversations with families (ie unclear custody arrangement, patient with significant mental health concerns, transportation/insurance access issues, etc), [redacted] will send a referral to [redacted] via the Apex referral system for follow-up.

Curious to know a few things...

1. What are your initial thoughts/responses/concerns to this proposed change of workflow?
2. Is a SWer required to make contact with every patient, or is it permissible for it to be as-indicated?
3. Can this questionnaire be simplified at all?

Happy to sit and have a meeting about this if you'd prefer! Thanks again for your partnership.

Obtained via CPRA by Judicial Watch, Inc.

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[redacted] & [redacted]

[redacted], LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 4:23 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted],

The DPH grant is ending as of 11/30/22, so all CAGC Social Work support going forward will be from the Medical Center. I'm hoping you and [redacted] can soon resolve the total Social Work FTE.

Please keep me posted on the search for the new CAGC Social Worker position.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

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Past Vice President and Director, Endocrine Society
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>
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Subject: RE: CAGC SW

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I was also under the impression that we had 2x 0.9 positions, but recently heard differently and was told we have 1.6 total for CACG. I will continue to explore this further.
If we actually do have only 1.6, do we still have access to the .3 FTE from the DPH grant?

Also, we have hired for the 2nd position, [redacted] is set to start on 11/7. We will send out a bio to the team soon.
I submitted an eRF to replace [redacted] and am waiting for this to be approved and posted.

Thank you,
[redacted] **LCSW**
Pediatric Social Work Manager

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<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi All,

I have cc'd [redacted]. We (the CAGC) have had a 0.9 FTE Social Worker paid for by the Medical Center, and, as on 2/17/22 (see email from [redacted], below), we were awarded an additional 0.9 FTE Social Worker based on the needs of the CAGC. Therefore, we should have two Social Workers, each at 0.9 FTE for the CAGC ASAP --The funding for the 2nd Social Worker was approved 8 months ago!

I understand that we have a replacement for the position currently held by [redacted], who will be leaving UCSF as of 11/11/22.

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To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC FTE Requests

All,

I have great news!

We received final approval on the 4.9 FTE investment request for CAGC. The positions are currently being posted by HR. Here's what was approved:

- 1.0 FTE Psychologist
- 1.0 FTE Practice Coordinator
- 0.9 FTE Social Worker
- 1.0 FTE LVN
- 1.0 FTE RN

I want to thank all of you for your patience as we worked to get this to the finish line. I also want to give kudos to [redacted] for her leadership in getting the request organized and building a compelling business case!

Thanks,

[redacted]

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[redacted], MBA
Director
Children's Ambulatory Services
UCSF Health

Office: (415) 514-6388
Mobile: [redacted]

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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 3:02 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: CAGC SW

Hi,

Please contact Steve and [redacted] regarding that information.

Thank you,

Dr. [redacted], DNP, AC-PNP-BC
Nurse Practitioner
UCSF Pediatric Endocrinology

From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:18 AM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks [redacted].

Any info on where the funding from the other .9 FTE is from, if it's not also Medical Center?

Thanks,
[redacted]

[redacted], LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
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From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:17 AM

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To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC SW

Here is the response on SW FTE:

2 x 0.9 FTE and one of those 0.9 FTE is from med center

[redacted] PNP
UCSF Pediatric Endocrinology
Assistant Clinical Professor
Department of Family Health Care
UCSF School of Nursing

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 29, 2022 10:00 AM PST
To: [redacted]@ucsf.edu>
Subject: Fw: Req# 70499BR CRC: New applicants

Hi [redacted]

Can you please take a look?

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 29, 2022 9:53 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Req# 70499BR CRC: New applicants

Hello,

There are 8 new applicants to review in BrassRing.

[redacted]
Pronouns: she, her, hers
Talent Acquisition Partner | UC San Francisco HR, Campus
T: [redacted] [redacted]@ucsf.edu
Clifton Strengths: Responsibility, Discipline, Input, Developer, Includer

http://www.ucsfhr.ucsf.edu/careers/
Follow us on Facebook & Twitter @ucsfcareers

UCPath
Learn more atucpath.ucsf.edu.

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From: [redacted]@ucsf.edu>
Sent: Tuesday, November 29, 2022 10:03 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Req# 70499BR CRC: New applicants

Hi Steve,

I still don't have access to Brassring. There was some tech error that [redacted] is trying to troubleshoot for me. I just emailed her again to follow up.

Thanks,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Date: Tuesday, November 29, 2022 at 10:00 AM
To: [redacted]@ucsf.edu>
Subject: Fw: Req# 70499BR CRC: New applicants

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Can you please take a look?

Thanks,

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Follow us on Facebook & Twitter @ucsfcareers

UCPath
Learn more at ucpath.ucsf.edu.

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From: [redacted]@ucsf.edu>
Sent: Tuesday, November 29, 2022 10:13 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi Steve,

That's a great question, and one that I'm not sure I have an answer to... I'm hopeful that as [redacted] has time to get settled into this role (and [redacted], too), it'll become more clear what capacity SW will have with the total FTE of 1.5. So perhaps it's a wait and see?

In the meantime, I would love to opportunity to come up with a plan for [redacted]'s workflow until her counterpart is hired.

Given your time away, should we aim for the afternoon of 12/16?

Let me know - thank you!
[redacted]

[redacted]LCSW
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Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted]

I think that you've made a clear and compelling argument for why having one social worker for the CAGC at 36 hours/week just doesn't cut it. It's my understanding that hiring a replacement for [redacted]) at 0.6 FTE (24 hours/week) is in process. Do you think that additional FTE will enable the ability for SW to carry out the tasks that have been so valued in our interdisciplinary model of care?

I'm happy to participate in a meeting to further discuss CAGC SW. I have most flexibility on Friday afternoons, but will be away 12/1-12/11.

Thanks very much,

Steve

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Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Monday, November 28, 2022 11:18 PM
To: [redacted], [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi everyone,

My apologies for the delay in my reply... and thank you for your thoughtful responses!

We hear you loud and clear - having SW do an initial assessment seems very important! We trust you know what your patients & families need.

However, the feedback we have been hearing from [redacted] for a long time is that their job responsibilities had become unsustainable. Doing all the pre-clinic assessments, helping families get connected with qualified community mental health professionals, and providing general and crisis support to established families had become too heavy of a workload (and this was with the help of 2 MSW students and some time from [redacted] (.2 FTE)).

We would like to re-define the essential tasks of SW in the CAGC, to ensure that we are expecting a reasonable amount of work out of [redacted] during her 36 hour work-week.

Can we find a time to meet in the next week and discuss the role of SW in CAGC going forward?

I assume you all are busier than I am, so please let me know when it's a good time to meet. Generally, I'm available most times except for Mondays and Thursday mornings.

A million thanks! And we are really looking forward to talking this through with you all.

[redacted]

[redacted] LCSW
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From: [redacted] [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, November 23, 2022 12:32 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks, [redacted], for putting so much thought into this. I feel strongly that the social worker, not the scheduler, takes full responsibility for any pre-clinic contact with the family aside from the scheduling. The pre-clinic questionnaire and social work contact is actually the beginning of the gender care prior to the first visit and requires someone trained to take on this role. To date, the social work team has been invaluable in this regard.

[redacted] [redacted], Ph.D,
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital

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1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

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Sent: Wednesday, November 23, 2022 11:00 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
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Subject: CAGC FTE Requests

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Children's Ambulatory Services
UCSF Health

Office: (415) 514-6388
Mobile: [redacted]

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 3:02 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: CAGC SW

Hi,

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Please contact Steve and [redacted] regarding that information.

Thank you,

Dr. [redacted], DNP, AC-PNP-BC
Nurse Practitioner
UCSF Pediatric Endocrinology

From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:18 AM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks [redacted].

Any info on where the funding from the other .9 FTE is from, if it's not also Medical Center?

Thanks,
[redacted]

[redacted], LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:17 AM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC SW

Here is the response on SW FTE:

2 x 0.9 FTE and one of those 0.9 FTE is from med center

[redacted], PNP
UCSF Pediatric Endocrinology
Assistant Clinical Professor
Department of Family Health Care
UCSF School of Nursing

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 29, 2022 10:16 AM PST
To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted]

Yes, Friday afternoon, 12/16, at 1 PM or later, works for me. Let's see what works for the others.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
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email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
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To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi Steve,

That's a great question, and one that I'm not sure I have an answer to... I'm hopeful that as [redacted] has time to get settled into this role (and [redacted], too), it'll become more clear what capacity SW will have with the total FTE of 1.5. So perhaps it's a wait and see?

In the meantime, I would love to opportunity to come up with a plan for [redacted]s workflow until her counterpart is hired.

Given your time away, should we aim for the afternoon of 12/16?

Let me know - thank you!
[redacted]

[redacted]LCSW
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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 29, 2022 9:22 AM

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To: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted]

I think that you've made a clear and compelling argument for why having one social worker for the CAGC at 36 hours/week just doesn't cut it. It's my understanding that hiring a replacement for [redacted]) at 0.6 FTE (24 hours/week) is in process. Do you think that additional FTE will enable the ability for SW to carry out the tasks that have been so valued in our interdisciplinary model of care?

I'm happy to participate in a meeting to further discuss CAGC SW. I have most flexibility on Friday afternoons, but will be away 12/1-12/11.

Thanks very much,

Steve

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email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Monday, November 28, 2022 11:18 PM
To: [redacted], [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]
[redacted]@ucsf.edu>
Cc [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi everyone,

My apologies for the delay in my reply... and thank you for your thoughtful responses!

We hear you loud and clear - having SW do an initial assessment seems very important! We trust you know what your patients & families need.

However, the feedback we have been hearing from [redacted] for a long time is that their job responsibilities had become unsustainable. Doing all the pre-clinic assessments, helping families get connected with qualified community mental health professionals, and providing general and crisis support to established families had become too heavy of a workload (and this was with the help of 2 MSW students and some time from [redacted](.2 FTE)).

We would like to re-define the essential tasks of SW in the CAGC, to ensure that we are expecting a reasonable amount of work out of [redacted] during her 36 hour work-week.

Can we find a time to meet in the next week and discuss the role of SW in CAGC going forward?

I assume you all are busier than I am, so please let me know when it's a good time to meet. Generally, I'm available most times except for Mondays and Thursday mornings.

A million thanks! And we are really looking forward to talking this through with you all.

[redacted]

[redacted]LCSW
Chief Clinical Social Worker

Obtained via CPRA by Judicial Watch, Inc.

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UCSF Benioff Children's Hospital

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From: [redacted]@ucsf.edu>
Sent: Wednesday, November 23, 2022 12:32 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks, [redacted], for putting so much thought into this. I feel strongly that the social worker, not the scheduler, takes full responsibility for any pre-clinic contact with the family aside from the scheduling. The pre-clinic questionnaire and social work contact is actually the beginning of the gender care prior to the first visit and requires someone trained to take on this role. To date, the social work team has been invaluable in this regard.

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Wednesday, November 23, 2022 11:00 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Good morning everyone,

[redacted] and I had a productive meeting with [redacted] last week about how to use this transitional time to better streamline patients' entry into the CAGC clinic.

Our understanding of the current state is: [redacted] contacts all patients with new patient appointments in the upcoming month, and completes the following questionnaire over the phone. This information is then put into the chart for providers to have at the ready for the patient's first visit. Copy of the assessment is here:
CAGC First Visit Questionnaire (1).docx

Our proposal for changes to make: [redacted] will conduct a simplified version of the questionnaire with families over the phone when she calls to schedule them. A week before their appointment, she will do a reminder call & offer to have a Social Worker ([redacted]) contact them for any additional support needs. Additionally, if [redacted] identifies any potential complicating psychosocial factors during her phone conversations with families (ie unclear custody arrangement, patient with significant mental health concerns, transportation/insurance access issues, etc), [redacted] will send a referral to [redacted] via the Apex referral system for follow-up.

Curious to know a few things...

1. What are your initial thoughts/responses/concerns to this proposed change of workflow?
2. Is a SWer required to make contact with every patient, or is it permissible for it to be as-indicated?
3. Can this questionnaire be simplified at all?

Happy to sit and have a meeting about this if you'd prefer! Thanks again for your partnership.

[redacted] & [redacted]

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[redacted] LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 4:23 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted]

The DPH grant is ending as of 11/30/22, so all CAGC Social Work support going forward will be from the Medical Center. I'm hoping you and [redacted] can soon resolve the total Social Work FTE.

Please keep me posted on the search for the new CAGC Social Worker position.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 4:00 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: RE: CAGC SW

Hello,

I was also under the impression that we had 2x 0.9 positions, but recently heard differently and was told we have 1.6 total for CACG. I will continue to explore this further.
If we actually do have only 1.6, do we still have access to the .3 FTE from the DPH grant?

Also, we have hired for the 2nd position, [redacted] is set to start on 11/7. We will send out a bio to the team soon.
I submitted an eRF to replace [redacted] and am waiting for this to be approved and posted.

Thank you,
[redacted] **LCSW**
Pediatric Social Work Manager
UCSF Benioff Children's Hospital, San Francisco

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Pediatric Social Work Department
1975 4th Street, Box 4012 | San Francisco, CA 94158
Office: 415.514-7668
Email: [redacted]@ucsf.edu
Pronouns: she, hers, her, ella

UCSF Benioff Children's Hospitals

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 3:21 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi All,

I have cc'd [redacted]. We (the CAGC) have had a 0.9 FTE Social Worker paid for by the Medical Center, and, as on 2/17/22 (see email from [redacted], below), we were awarded an additional 0.9 FTE Social Worker based on the needs of the CAGC. Therefore, we should have two Social Workers, each at 0.9 FTE for the CAGC ASAP --The funding for the 2nd Social Worker was approved 8 months ago!

I understand that we have a replacement for the position currently held by [redacted], who will be leaving UCSF as of 11/11/22.

Please let me know if the position for the 2nd Social Worker has been posted, and if not yet posted, please let me know when this is likely to happen. Again, the funding for the 2nd Social Worker was approved 8 months ago, so we really need to move forward with the hiring process.

Thank you,

Steve

From: [redacted]@ucsf.edu>
Sent: Thursday, February 17, 2022 4:42 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC FTE Requests

All,

I have great news!

We received final approval on the 4.9 FTE investment request for CAGC. The positions are currently being posted by HR. Here's what was approved:

- 1.0 FTE Psychologist
- 1.0 FTE Practice Coordinator
- 0.9 FTE Social Worker
- 1.0 FTE LVN
- 1.0 FTE RN

I want to thank all of you for your patience as we worked to get this to the finish line. I also want to give kudos to [redacted] for her leadership in getting the request organized and building a compelling business case!

Thanks,

[redacted]

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[redacted]MBA
Director
Children's Ambulatory Services
UCSF Health

Office: (415) 514-6388
Mobile: [redacted]

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Subject: Re: CAGC SW

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Please contact Steve and [redacted] regarding that information.

Thank you,

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UCSF Pediatric Endocrinology

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Thanks [redacted]

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Thanks,
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To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC SW

Here is the response on SW FTE:

2 x 0.9 FTE and one of those 0.9 FTE is from med center

[redacted] PNP
UCSF Pediatric Endocrinology
Assistant Clinical Professor
Department of Family Health Care
UCSF School of Nursing

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 29, 2022 10:19 AM PST
To: [redacted]@ucsf.edu>
Subject: Re: Req# 70499BR CRC: New applicants

Is ANYTHING ever easy at UCSF????

Thanks, :)

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
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email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 29, 2022 10:03 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Req# 70499BR CRC: New applicants

Hi Steve,

I still don't have access to Brassring. There was some tech error that [redacted] is trying to troubleshoot for me. I just emailed her again to follow up.

Thanks,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Date: Tuesday, November 29, 2022 at 10:00 AM
To: [redacted]@ucsf.edu>
Subject: Fw: Req# 70499BR CRC: New applicants

Hi [redacted],

Can you please take a look?

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
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From: [redacted]@ucsf.edu>

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Sent: Tuesday, November 29, 2022 9:53 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Req# 70499BR CRC: New applicants

Hello,

There are 8 new applicants to review in BrassRing.

[redacted]
Pronouns: she, her, hers
Talent Acquisition Partner | UC San Francisco HR, Campus
T: 415-514-1110 [redacted]@ucsf.edu
Clifton Strengths: Responsibility, Discipline, Input, Developer, Includer

http://www.ucsfhr.ucsf.edu/careers/
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Learn more atucpath.ucsf.edu.

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, November 29, 2022 10:57 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

I would be available 3 pm to 5:30 pm on 12/16.

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

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Sent: Tuesday, November 29, 2022 10:16 AM
To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

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Thanks,

Steve

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Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

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In the meantime, I would love to opportunity to come up with a plan for [redacted] workflow until her counterpart is hired.

Given your time away, should we aim for the afternoon of 12/16?

Let me know - thank you!
[redacted]

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[redacted], LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 29, 2022 9:22 AM
To: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted]

I think that you've made a clear and compelling argument for why having one social worker for the CAGC at 36 hours/week just doesn't cut it. It's my understanding that hiring a replacement for [redacted]) at 0.6 FTE (24 hours/week) is in process. Do you think that additional FTE will enable the ability for SW to carry out the tasks that have been so valued in our interdisciplinary model of care?

I'm happy to participate in a meeting to further discuss CAGC SW. I have most flexibility on Friday afternoons, but will be away 12/1-12/11.

Thanks very much,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Monday, November 28, 2022 11:18 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi everyone,

My apologies for the delay in my reply... and thank you for your thoughtful responses!

We hear you loud and clear - having SW do an initial assessment seems very important! We trust you know what your patients & families need.

However, the feedback we have been hearing from [redacted] for a long time is that their job responsibilities had become

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unsustainable. Doing all the pre-clinic assessments, helping families get connected with qualified community mental health professionals, and providing general and crisis support to established families had become too heavy of a workload (and this was with the help of 2 MSW students and some time from [redacted] (.2 FTE)).

We would like to re-define the essential tasks of SW in the CAGC, to ensure that we are expecting a reasonable amount of work out of [redacted] during her 36 hour work-week.

Can we find a time to meet in the next week and discuss the role of SW in CAGC going forward?

I assume you all are busier than I am, so please let me know when it's a good time to meet. Generally, I'm available most times except for Mondays and Thursday mornings.

A million thanks! And we are really looking forward to talking this through with you all.

[redacted]

[redacted] LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, November 23, 2022 12:32 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks, [redacted], for putting so much thought into this. I feel strongly that the social worker, not the scheduler, takes full responsibility for any pre-clinic contact with the family aside from the scheduling. The pre-clinic questionnaire and social work contact is actually the beginning of the gender care prior to the first visit and requires someone trained to take on this role. To date, the social work team has been invaluable in this regard.

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Wednesday, November 23, 2022 11:00 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Good morning everyone,

[redacted] and I had a productive meeting with [redacted] last week about how to use this transitional time to better streamline patients' entry into the CAGC clinic.

Our understanding of the current state is: [redacted] contacts all patients with new patient appointments in the upcoming month, and completes the following questionnaire over the phone. This information is then put into the chart for providers to have at the ready for the patient's first visit. Copy of the assessment is here:

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CAGC First Visit Questionnaire (1).docx

Our proposal for changes to make: [redacted] will conduct a simplified version of the questionnaire with families over the phone when she calls to schedule them. A week before their appointment, she will do a reminder call & offer to have a Social Worker ([redacted] contact them for any additional support needs. Additionally, if [redacted] identifies any potential complicating psychosocial factors during her phone conversations with families (ie unclear custody arrangement, patient with significant mental health concerns, transportation/insurance access issues, etc) [redacted] will send a referral to [redacted] via the Apex referral system for follow-up.

Curious to know a few things...

1. What are your initial thoughts/responses/concerns to this proposed change of workflow?
2. Is a SWer required to make contact with every patient, or is it permissible for it to be as-indicated?
3. Can this questionnaire be simplified at all?

Happy to sit and have a meeting about this if you'd prefer! Thanks again for your partnership.

[redacted] & [redacted]

[redacted] LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 4:23 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted],

The DPH grant is ending as of 11/30/22, so all CAGC Social Work support going forward will be from the Medical Center. I'm hoping you and [redacted] can soon resolve the total Social Work FTE.

Please keep me posted on the search for the new CAGC Social Worker position.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 4:00 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]

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[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: RE: CAGC SW

Hello,

I was also under the impression that we had 2x 0.9 positions, but recently heard differently and was told we have 1.6 total for CACG. I will continue to explore this further.
If we actually do have only 1.6, do we still have access to the .3 FTE from the DPH grant?

Also, we have hired for the 2nd position, [redacted] is set to start on 11/7. We will send out a bio to the team soon.
I submitted an eRF to replace [redacted] and am waiting for this to be approved and posted.

Thank you,
[redacted] **LCSW**
Pediatric Social Work Manager
UCSF Benioff Children's Hospital, San Francisco

Pediatric Social Work Department
1975 4th Street, Box 4012 | San Francisco, CA 94158
Office: 415.514-7668
Email: [redacted]@ucsf.edu
Pronouns: she, hers, her, ella

UCSF Benioff Children's Hospitals

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 3:21 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi All,

I have cc'd [redacted] We (the CAGC) have had a 0.9 FTE Social Worker paid for by the Medical Center, and, as on 2/17/22 (see email from [redacted] below), we were awarded an additional 0.9 FTE Social Worker based on the needs of the CAGC. Therefore, we should have two Social Workers, each at 0.9 FTE for the CAGC ASAP --The funding for the 2nd Social Worker was approved 8 months ago!

I understand that we have a replacement for the position currently held by [redacted], who will be leaving UCSF as of 11/11/22.

Please let me know if the position for the 2nd Social Worker has been posted, and if not yet posted, please let me know when this is likely to happen. Again, the funding for the 2nd Social Worker was approved 8 months ago, so we really need to move forward with the hiring process.

Thank you,

Steve

From: [redacted]@ucsf.edu>
Sent: Thursday, February 17, 2022 4:42 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC FTE Requests

All,

I have great news!

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We received final approval on the 4.9 FTE investment request for CAGC. The positions are currently being posted by HR. Here's what was approved:

- 1.0 FTE Psychologist
- 1.0 FTE Practice Coordinator
- 0.9 FTE Social Worker
- 1.0 FTE LVN
- 1.0 FTE RN

I want to thank all of you for your patience as we worked to get this to the finish line. I also want to give kudos to [redacted] for her leadership in getting the request organized and building a compelling business case!

Thanks,

[redacted]

[redacted] MBA
Director
Children's Ambulatory Services
UCSF Health

Office: (415) 514-6388
Mobile: [redacted]

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 3:02 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: CAGC SW

Hi,

Please contact Steve and [redacted] regarding that information.

Thank you,

Dr. [redacted], DNP, AC-PNP-BC
Nurse Practitioner
UCSF Pediatric Endocrinology

From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:18 AM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks [redacted]

Any info on where the funding from the other .9 FTE is from, if it's not also Medical Center?

Thanks,
[redacted]

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[redacted] LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:17 AM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC SW

Here is the response on SW FTE:

2 x 0.9 FTE and one of those 0.9 FTE is from med center

[redacted] PNP
UCSF Pediatric Endocrinology
Assistant Clinical Professor
Department of Family Health Care
UCSF School of Nursing

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From: Rosenthal, Stephen
Sent: Tuesday, November 29, 2022 11:02 AM PST
To: [redacted]@ucsf.edu>
Subject: Attending schedule for December 1-11

Hi [redacted],

I hope you had a nice Thanksgiving!

Please send me the Attending schedule for December 1-11.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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From: [redacted]@ucsf.edu>
Sent: Tuesday, November 29, 2022 11:34 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Attending schedule for December 1-11

Hi Steve,

[redacted] is on service December 1-11.

Hope you enjoyed the holiday break.

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 29, 2022 11:02 AM
To: [redacted]@ucsf.edu>
Subject: Attending schedule for December 1-11

Hi [redacted]

I hope you had a nice Thanksgiving!

Please send me the Attending schedule for December 1-11.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
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San Francisco CA 94143-0434
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 29, 2022 11:35 AM PST
To: [redacted]@ucsf.edu>
Subject: Re: Attending schedule for December 1-11

Thank you!

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 29, 2022 11:34 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Attending schedule for December 1-11

Hi Steve,

[redacted] is on service December 1-11.

Hope you enjoyed the holiday break.

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 29, 2022 11:02 AM
To: [redacted]@ucsf.edu>
Subject: Attending schedule for December 1-11

Hi [redacted]

I hope you had a nice Thanksgiving!

Please send me the Attending schedule for December 1-11.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
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Pronouns: he/him/his

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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 29, 2022 12:43 PM PST
To: [redacted] <[redacted]@nature.com>
Subject: Re: Manuscript accepted for publication in Nature Reviews Endocrinology

Dear [redacted],

I hope this finds you well!

Please forgive my very delayed response to your email--I truly apologize. First, thank you for the update about the number of times my article has been shared or accessed on-line. I do continue to share the article with colleagues and have also cited it in two recent reviews and in two book chapters. Thank you also for your kind invitation to visit your offices--I have no current plans to be in London, but will certainly let you know if/when I do!

I want to thank you again for the privilege of writing an article for*Nature Reviews Endocrinology.* It really meant a lot to me!

With all best wishes,

Sincerely,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@nature.com>
Sent: Thursday, September 15, 2022 9:26 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: Manuscript accepted for publication in Nature Reviews Endocrinology

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Dear Steve,

I hope this email finds you well. It has now been around 1 year since your article on 'Challenges in the care of transgender and gender-diverse youth: an endocrinologist's view' was published in *Nature Reviews Endocrinology*, so I wanted to get in touch to give you an update on how the article is doing. I'm also re-sending the Powerpoint slide deck of your figures, which you can use in upcoming talks, and the PDF.

Online, all of our articles have an article metrics page, which contains information on citations and social media activity related to the article. As you can see from your article's metrics page (https://www.nature.com/articles/s41574-021-00535-9/metrics), your article has been shared online regularly and has been cited 5 times so far. We also have access to Google Analytics, which allows us to assess how many people have accessed your article online. Since publication in August 2021, your article has been accessed >2,400 times.

We have been promoting your article through our social media accounts, and will continue to do this over the coming months. It would also be great if you could continue to share the article with your colleagues. If you would like to cite your article the citation is — Rosenthal, S.M. Challenges in the care of transgender and gender-diverse youth: an endocrinologist's view.*Nat. Rev. Endocrinol.* **17**, 581–591 (2021). The article can be read (but not downloaded or printed) via ReadCube at this link (https://rdcu.be/cVFal).

As you can see, feedback on the article has been positive so far, and we hope that it will continue to be useful to your colleagues in the field. In addition, you are very welcome to visit our offices (the team is based in our London offices), and please do let me know if you have any feedback on the article or ideas for topics we could cover in the future.

I very much enjoyed working with you on this article, and hope to work with you again in the future.

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

With best wishes,
[redacted]

[redacted]
(she/her/hers –more information why)
Chief Editor, *Nature Reviews Endocrinology*
Nature Portfolio

The Campus, 4 Crinan Street, London, N1 9XW, UK
T: [redacted]
[redacted]@nature.com
ORCID: 0000-0001-9855-974X
@NatureRevEndo | facebook.com/NatureReviews
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From: [redacted]
Sent: 13 September 2021 11:59
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: Manuscript accepted for publication in Nature Reviews Endocrinology

Dear Steve,

Thanks so much for your feedback – I am so glad that you like the cover. And thank you also for your kind words about [redacted] he is doing much better now.

With best wishes,
[redacted]

[redacted]
(she/her/hers –more information why)
Chief Editor, *Nature Reviews Endocrinology*
Nature Portfolio

The Campus, 4 Crinan Street, London N1 9XW, UK
T: [redacted]
[redacted]@nature.com
ORCID: 0000-0001-9855-974X
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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: 10 September 2021 19:22
To: [redacted] <[redacted]@nature.com>
Subject: Re: Manuscript accepted for publication in Nature Reviews Endocrinology

[External - Use Caution]
Dear [redacted],

Thank you so much for featuring my article on the cover of the October issue. I am deeply honored and touched, and especially grateful that the science in the care of transgender youth will have greater visibility and hopefully contribute in a positive way to the discourse on this complex subject.

Thank you again to you, and of course to [redacted] (I hope he is in better health, wherever he is) for the opportunity and honor to have written for *Nature Reviews Endocrinology.*

With all best wishes,

Sincerely,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics

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Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
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Director, World Professional Association for Transgender Health
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Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@nature.com>
Sent: Thursday, September 9, 2021 2:48 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: Manuscript accepted for publication in Nature Reviews Endocrinology

Dear Stephen,

I hope you are well. I am writing to let you know that we have featured your article on the cover of our October issue to further increase its visibility. The October cover is currently displayed on our journal homepage: https://www.nature.com/nrendo/. I've also attached a copy of the cover for your personal use only.

It was a pleasure working with you and I hope that we can do so again in the future.

Best wishes,
[redacted]

[redacted]
(she/her/hers –more information why)
Chief Editor, *Nature Reviews Endocrinology*
Nature Portfolio

The Campus, 4 Crinan Street, London N1 9XW, UK
T: [redacted]
[redacted]@nature.com
ORCID: 0000-0001-9855-974X
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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: 01 July 2021 17:21
To: [redacted] <[redacted]@nature.com>; [redacted] <[redacted]@nature.com>
Cc: [redacted] <[redacted]@nature.com>
Subject: Re: Manuscript accepted for publication in Nature Reviews Endocrinology

[External - Use Caution]
Dear [redacted],

Thanks very much!

Best wishes,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@nature.com>
Sent: Wednesday, June 30, 2021 2:36 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted] <[redacted]@nature.com>
Subject: RE: Manuscript accepted for publication in Nature Reviews Endocrinology

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Best wishes,
[redacted]

[redacted]
(she/her/hers –more information why)
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T: [redacted]
[redacted]@nature.com
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Here are the Twitter handles you requested:

My Twitter handle: @Smr94117

For my institution: @UCSFChildrens
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Thanks and best wishes,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434

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Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@nature.com <[redacted]@nature.com>
Sent: Monday, June 28, 2021 2:40 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Manuscript accepted for publication in Nature Reviews Endocrinology

Dear Steve,

Manuscript number: NREND-18-124V1C
Title: Challenges in the care of transgender and gender diverse youth: an endocrinologist's view
Authors: Stephen Rosenthal

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Thanks again for writing for Nature Reviews Endocrinology. I have enjoyed working with you on this project.

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The Evolution of Adolescent Gender-Affirming Care: An Historical Perspective

Jeremi M. Carswell[a] Ximena Lopez[b] Stephen M. Rosenthal[c]

[a]Endocrinology Division, Department of Pediatrics, Boston Children's Hospital, Boston, MA, USA; [b]Division of Pediatric Endocrinology, Department of Pediatrics, Southwestern Medical Center, University of Texas, Dallas, TX, USA; [c]Division of Pediatric Endocrinology, Department of Pediatrics, Benioff Children's Hospital, University of California San Francisco, San Francisco, CA, USA

Keywords
Transgender · Gender-affirming care · Gender identity · Biology of gender · Adolescence · Pubertal blockers · Gender-affirming hormones

Abstract
While individuals have demonstrated gender diversity throughout history, the use of medication and/or surgery to bring a person's physical sex characteristics into alignment with their gender identity is relatively recent, with origins in the first half of the 20th century. Adolescent gender-affirming care, however, did not emerge until the late 20th century and has been built upon pioneering work from the Netherlands, first published in 1998. Since that time, evolving protocols for gender-diverse adolescents have been incorporated into clinical practice guidelines and standards of care published by the Endocrine Society and World Professional Association for Transgender Health, respectively, and have been endorsed by major medical and mental health professional societies around the world. In addition, in recent decades, evidence has continued to emerge supporting the concept that gender identity is not simply a psychosocial construct but likely reflects a complex interplay of biological, environmental, and cultural factors. Notably, however, while there has been increased acceptance of gender diversity in some parts of the world, transgender adolescents and those who provide them with gender-affirming medical care, particularly in the USA, have been caught in the crosshairs of a culture war, with the risk of preventing access to care that published studies have indicated may be lifesaving. Despite such challenges and barriers to care, currently available evidence supports the benefits of an interdisciplinary model of gender-affirming medical care for transgender/gender-diverse adolescents. Further long-term safety and efficacy studies are needed to optimize such care.

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Introduction

The relatively recent recognition of diversity of "gender identity" – one's inner sense of self as male or female or somewhere on the gender spectrum – in the current culture belies its long-standing presence in cultures diverse and ancient. "Transgender" (sometimes referred to as "gender incongruence") is defined as a marked and persistent incongruence between an individual's experienced gender and their sex designated at birth. Transgender is often used as an umbrella term to encompass all gender identities that are not the same as the birth-assigned gender (typically based on the sex designated at

Karger@karger.com
www.karger.com/hrp

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Correspondence to:
Stephen M. Rosenthal, stephen.rosenthal@ucsf.edu

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birth) but may also be used specifically for a binary gender identification.

As our understanding of gender has been evolving over time, so has the language used to describe gender. Throughout this manuscript, the authors have primarily used the terminology of the present day, though historical descriptions will contain language that is clearly outdated. We have chosen to use these terms only to maintain the historical perspective in this context.

The Historic and Cultural Diversity of Gender

Though it may seem that transgender as a concept is a recent phenomenon, there are both ancient and diverse examples that underscore the understanding that humans have experienced gender as beyond the set of cultural norms assigned to them based on their genitals. In Greek and Roman mythology, there are legends of deities who defy traditional concepts of gender; the most famous may be Hermaphroditus, a son born of Hermes and Aphrodite. When the nymph Salmacis fell in love with him, their forms became merged, with the god depicted as having male genitalia with breasts and a more feminine body shape [1, 2]. Norse mythology gives us the notorious shape and sex shifting Loki, who was known for his trickery, appearing at times in a female form when it suited his purpose [1]. Several Indigenous North American tribes have long-standing recognition and language for gender and/or sexual minority-identified individuals that often signified a third gender, or a combination of male and female. Though the designation and roles varied among tribes, the term "two-spirit" was coined in 1990 during the international LGBT Native American Gathering and attributed to Elder Maya Laramee [3, 4]. This term is not specific to any one tribe or any one group of individuals but encompasses any indigenous member with gender-diverse identification or same-sex attraction.

Biological Underpinnings of Gender Identity

John Money, a New Zealand psychologist and faculty member in pediatrics at Johns Hopkins University beginning in the early 1950s, and co-founder of the Gender Identity Clinic at that university, promoted the concept that gender identity was influenced by "social learning and memory" in conjunction with biological factors [5]. However, a widely publicized case described in a book by John Colapinto published in 2000 lends strong support to the concept that gender identity is not primarily learned [6]. This book focused on a failed circumcision in an 8-month-old male resulting in loss of the penis, leading Money to advise the family to castrate the infant and raise him as a girl [6]. The child never accepted a female gender identity, became severely depressed, and changed gender to male during adolescence. He later committed suicide [6]. In subsequent years, evidence in support of biological underpinnings to gender identity development has continued to emerge, derived primarily from three biomedical disciplines: genetics, endocrinology, and neurobiology [7].

Starting in the late 1970s, heritability of being transgender was suggested from studies describing concordance of gender identity in monozygotic twin pairs and in father-son and brother-sister pairs [8, 9]. In the largest twin study evaluating gender identity, in which at least one member of a twin pair was transgender, there was a much greater likelihood that the other member of the twin pair was also transgender if they were identical versus nonidentical (but same sex) twins [10]. Attempts to identify polymorphisms in candidate genes that might be more prevalent in transgender versus cisgender individuals have been inconsistent. In particular, a 2009 study from Japan did not find any significant associations of transsexualism with polymorphisms in five candidate genes (encoding the androgen receptor, CYP19, ER-alpha, ER-beta, and the progesterone receptor) [11]. However, a 2019 study in 380 transgender women and 344 cisgender male controls demonstrated an over-representation of several allele combinations involving the androgen receptor in transgender women [12]. A subsequent study using whole-exome sequencing in a relatively small number of transgender males (n = 13) and transgender females (n = 17) demonstrated 21 variants in 19 genes that were associated with previously described estrogen receptor-activated pathways of sexually dimorphic brain development [13]. An association between polymorphisms in the estrogen receptor alpha gene promoter and a transgender male identity has also been reported [14].

The vast majority of transgender individuals do not have an intersex condition or any associated abnormality in sex steroid production or responsiveness [7]. However, studies in a variety of intersex conditions have informed our understanding of the potential role of hormones, particularly prenatal and early postnatal androgens, in gender identity development [7]. For example, several studies of 46,XX individuals with virilizing congenital adrenal hyperplasia caused by 21-hydroxylase deficiency demonstrated a greater prevalence of a transgender identity out-

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come (female to male) compared to the general population [15–17]. One such study published in 2006 demonstrated a relationship between severity of congenital adrenal hyperplasia and gender identity outcome, where 7% of patients with the severe salt-wasting form had gender dysphoria or a male gender identity, while no gender dysphoria was seen in any of the less severely affected individuals [16]. Studies in a variety of other hormonal and nonhormonal intersex conditions support a role of prenatal and/or postnatal androgens in gender identity development [7]. However, in 2011, a case report in a 46,XY individual with complete androgen insensitivity and a male gender identity challenged the concept that androgen receptor signaling is required for male gender identity development [18].

Neuroimaging studies that aim to understand the neurobiology of gender identity indicate that some sexually dimorphic brain structures are more closely aligned with gender identity than with physical sex characteristics in transgender adults prior to treatment with gender-affirming hormones [19–21]. A similar trend was reported in studies of gray matter in youth with gender dysphoria [22]. In 2021, an MRI study in transgender adults, also prior to treatment with gender-affirming sex hormones, found that transgender people have a unique brain phenotype "rather than being merely shifted towards either end of the male-female spectrum" [23]. Notably, in both transgender adolescents and adults, several functional brain studies looking at responses to odorous compounds or mental rotation tasks demonstrated that patterns typically observed to be sexually dimorphic were more closely aligned with gender identity than with physical sex characteristics, even before treatment with gender-affirming sex hormones [24–26].

History of Modern Gender-Affirming Medical Treatment

Though individuals have demonstrated gender diversity throughout history, the use of medication and/or surgery is relatively recent with origins in Germany in the first half of the 20th century and is credited to the pioneering work of Magnus Hirschfeld. The institution he founded, "Institut für Sexualwissenschaft (the Institute for Sexual Science)" in Berlin (1922), paved the way for the use of hormones and surgery [27]. In Hirschfeld's study of what he named "sexual intermediaries," he recognized that people may be born with a nature contrary to their assigned gender. In cases where the desire to live as the opposite sex was strong, he thought science ought to provide a means of transition. Innovative for his time, he argued that a person may be born with characteristics that did not fit into heterosexual or binary categories and supported the idea that a "third sex" existed naturally [27]. The first documented case of genital surgery was performed at the institute on Dorchen Richter in 1922 with orchiectomy and then 1931 with penectomy and vaginoplasty [27, 28]. Notable patients, including Lili Elbe (born Einar Wegener), the patient on whom the movie "The Danish Girl" is based, underwent a series of operations including transplant of both ovaries and a uterus [29].

This clinic would be a century old if it had not fallen victim to Nazi ideology and Hitler's mission to rid Germany of Lebensunwertes Leben, or "lives unworthy of living." What began as a sterilization program ultimately led to the extermination of millions of Jews, Gypsies, Soviet, and Polish citizens, as well as homosexuals and transgender people. When the Nazis came for the institute in 1933, Hirschfeld had fled to France. Troops swarmed the building and created a bonfire that engulfed more than 20,000 of his books, some of them rare copies that had helped provide a history for transgender people [27].

In the 1950s, German-American physician Harry Benjamin (1885–1986) introduced the term "transsexuality," defining a "transsexual" person as someone who identifies in opposition to their "biological sex" [30]. Harry Benjamin graduated cum laude from medical school in Tübingen, Germany, in 1912. He moved to New York City in 1914 to study tuberculosis, but over time, he became known as a geriatrician, endocrinologist, and sexologist [31]. He did not treat his first transgender patient until he was in his 60s, and his colleagues described him as follows: "Being a true physician, Benjamin treated all these patients as people and by respectfully listening to each individual voice, he learned from them what gender dysphoria was about" [32]. Notably, he did not describe "transsexualism" as a psychological problem, but as a biological condition that could be treated with hormone or surgical therapy [31]. He treated over 1,500 patients, and in 1966, he published the first medical textbook in this field, "The Transsexual Phenomenon" [33]. His work was very influential, and he became known as "The Father of Transsexualism" [31, 32].

Following World War II, gender-affirming treatment in the USA was limited to wealthy patients who could afford to travel to Europe, though they did so at great risk given the laws in several states outlawing "cross-dressing" [34]. Christine Jorgensen (1926–1989) brought visibility

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to transgender patients, having undergone medical and surgical transition in Europe after she had served time in the US military as a male [35].

Influenced by Dr. Benjamin Harris' "The Transsexual Phenomenon" [33], Johns Hopkins Hospital in Baltimore became the first academic institution in the USA to offer gender-affirming surgery [36]. Soon after, at least another 8 academic institutions opened transgender programs throughout the 1960–1970s (University of Minnesota, University of Washington, Northwestern/Cook County Health in Chicago, Stanford University, Cleveland Clinic, University of Colorado, Baptist Medical Center in Oklahoma City, and Washington University in St. Louis) [37].

Toward the end of the 1970s, however, most transgender programs closed access to new patients. These closures were done quietly out of public view, and the causes were often not disclosed [37]. At Johns Hopkins Hospital, Paul McHugh became the Chair of Psychiatry in 1975. From the moment he was hired, McHugh openly stated he intended to stop gender-affirming surgery at this hospital [38]. Under his leadership, another Johns Hopkins psychiatrist, Dr. Jon Meyer, published a study of 50 patients which concluded that gender-affirming surgery did not provide "objective" benefit for transgender individuals [39]. This publication led to the sudden closure of the clinic in 1979 [36]. Interestingly, John Money, who believed that gender could be learned and who co-founded the Johns Hopkins gender clinic, publicly expressed opposition to Meyer's conclusions of his study [36].

The program at the Baptist Medical Center in Oklahoma City had been functioning since 1973. However, in 1977, its existence was brought to the attention of the Board of Directors of the Baptist General Convention of Oklahoma. This led to a 54-2 vote by the Board of Directors at the Baptist Medical Center to close the program. Physicians who passionately advocated to continue this practice issued a joint statement saying, "If Jesus Christ were alive today, undoubtedly he would render help and comfort to the transsexual" [37].

It is thought that publicity around the Meyer paper [39] from Johns Hopkins played a role in an escalation of closure of other clinics [37]. Despite these closures, academic interest in the field led to the foundation of the Harry Benjamin Gender Dysphoria Association in 1979 [40]. This association had the goal of organizing professionals who were interested in the "study and care of transsexualism and gender dysphoria." It has since been renamed the World Professional Association for Transgender Health (WPATH) and has evolved into a large international multidisciplinary organization that provides Standards of Care for the treatment of transgender/gender-diverse (TGD) adolescents and adults [41].

In 1980, "transsexualism" and "gender identity disorder of childhood" were both recognized as illnesses in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders [42]. In 2013, the term "gender identity disorder" was replaced by "gender dysphoria in children" and "gender dysphoria in adolescents and adults" to diagnose and treat those transgender individuals who felt distress at the mismatch between their gender identities and their bodies, with the American Psychiatric Association stating that "it is important to note that gender nonconformity is not in itself a mental disorder" [43].

In 2019, the World Health Organization International Classification of Diseases version 11 replaced International Classification of Diseases-10's "transsexualism" and "gender identity disorder of children" with "gender incongruence of adolescence and adulthood" and "gender incongruence of childhood," respectively [44]. Gender incongruence was moved out of the "Mental and behavioral disorders" chapter into a new chapter, entitled "Conditions related to sexual health" [44]. This reflects current perspective that TGD identities are not mental health illnesses and that classifying them as such can cause significant stigma.

History of Gender-Affirming Medical Treatment in Adolescents

Providers in the Netherlands recognized the importance of preventing progression of a gender incongruent puberty by using a gonadotropin hormone-releasing hormone analog (GnRHa) followed by treatment with either testosterone or estrogen to bring physical characteristics into alignment with a patient's gender identity [45, 46]. This approach was first published by Drs. Cohen-Kettenis and van Goozen in 1998 in a case report of an adolescent treated with GnRHa by **Dr. Henriette A. Delemarre-van de Waal** (though not named in the publication) (Dr. **Sabine E. Hannema**, personal communication) [47]. Under the direction of Dr. Peggy Cohen-Kettenis, the first program geared to treating adolescents with gender dysphoria was established in the Netherlands [45]. Initially based on the guidelines of adult transgender treatment established by the Harry Benjamin Society and adapted to adolescents, patients first underwent comprehensive psychological assessment to establish a diagnosis of gender dysphoria (then called "gender identity disorder") and then initiated treatment with GnRH agonists (Gn-

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RHa) typically at Tanner 2–3 to pause pubertal development [45, 46]. The time spent under pubertal suppression would be used to further explore gender identity prior to committing to either estrogen or testosterone and their physical effects. This intervention with a GnRHa would also be somewhat of a diagnostic aid in that if it eased the distress; it was reasonable to correlate the distress with gender dysphoria as a primary cause. This was followed by hormone therapy around age of 16 years and then gender-affirming genital surgery at 18 years or later [45, 46, 48]. The "Dutch Protocol" [49] was adapted by practitioners internationally, though it was not until pediatric endocrinologist and adolescent medicine pediatrician **Dr. Norman Spack**, having traveled to Amsterdam to observe the clinic there, established the first formal US program geared specifically to transgender adolescents at Boston Children's Hospital: the Gender Management (subsequently replaced with Multispecialty) Service program in 2007 [50]. It should be noted that adolescents there and elsewhere across the USA had been treated outside of a structured program [50]. Clinical protocols at Gender Management Service were derived from direct observation, adaptation of the Dutch program, and a May 2005 consensus meeting (the Gender Identity Research and Education Society) and expanded upon previous guidelines from the Standards of Care of the WPATH and those from the Royal College of Psychiatrists [46, 51, 52].

The Endocrine Society guidelines, with input from the Pediatric Endocrine Society, the European Society for Paediatric Endocrinology, the European Society for Endocrinology, and WPATH, were first published in 2009 and recommended the use of GnRHa as a treatment for selected adolescents [53]. Pubertal suppression could be initiated when the individual reached Tanner 2 or 3, followed by gender-affirming hormones at age of 16 years. Subsequent standards of care and clinical practice guidelines published by WPATH (SOC 8 in 2022) [41], the University of California San Francisco in 2016 [54], and the Endocrine Society (updated in 2017) [55] continued to recommend treatment for adolescents starting with pubertal suppression at Tanner 2 and 3, with consideration of gender-affirming sex hormones in some adolescents younger than 16 years old (on a case-by-case basis) who had demonstrated strong and persistent gender dysphoria. Of note, the WPATH SOC 8 does not list minimum age requirements for gender-affirming medical care [41].

In 2014, a published resource guide providing contact information showed that there were 32 US and 2 Canadian programs available to treat TGD adolescents [56]. As of March 2022, there were about 60 recognized pediatric/adolescent multidisciplinary gender programs in the USA, though smaller programs and individual offices probably also provide care [57]. Some programs have been closed for political reasons with potentially dire consequences for both patients and practitioners [58].

Changing Prevalence of Trans Identities and the Rise of Nonbinary Identification

Worldwide, the prevalence of people declaring a gender identity that is different from that assigned at birth has risen sharply as the recognition of gender diversity, and its social acceptance has increased. Early estimates of prevalence for those seeking hormonal treatment are notable for relatively low prevalence and a heavy predominance of birth-assigned males. In 1968, two authors published estimates demonstrating this trend. In the USA, Pauly cited 1:100,000 birth-assigned males and 1:400,000 birth-assigned females [59]. In Sweden, the estimate again favored the birth-assigned males at 1:37,000 and birth-assigned females at 1:103,000 [60]. By the mid-80s, numbers had risen with a similar ratio of birth-assigned males at 1:18,000 and birth-assigned females at 1:54,000 [61]. The same year, authors in Singapore reported much higher numbers of 1:2,900 and 1:8,300 birth-assigned males and females, respectively [62]. The Williams Institute of the University of California Los Angeles School of Law has tracked prevalence of transgender identification in the USA. A report from 2022 (based on data from 2017, 2019, and 2020) revealed that the prevalence of adults in the USA who identified as transgender has remained stable at around 0.5% of the population, or 1.3 million adults. However, the percentage of trans-identified youth (ages 13–17) had notably increased in recent years from 0.7% to 1.4% of the population [63]. Recent reports have also noted a rise in nonbinary gender identification and a reversal in the sex ratio of adolescents presenting for gender-affirming care from a predominance of those designated male at birth to a predominance of individuals designated female at birth. In 2017, a large adolescent multidisciplinary survey noted that 63% of the presenting patients were birth-assigned females [64].

Legislative and Social Dynamics

Since 2016, many US states and European countries have introduced laws that restrict transgender youth from accessing gender-affirming care, team sports, and

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restrooms that are consistent with their gender identity [65]. Simultaneously, numerous reputable national and international academic medical societies have openly and repeatedly stated their opposition to these laws. This includes the Pediatric Endocrine Society [66, 67], the Endocrine Society [68, 69], the American Academy of Pediatrics [70], the American Medical Association [71], the United States Professional Association for Transgender Health [72], the American Association for Child and Adolescent Psychiatry [73], and in a united statement, also the American Psychiatric Association, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the American Osteopathic Association [74].These societies have stated that these bills are discriminatory and cause harm to the mental health of transgender youth. Despite this, some bills have passed successfully [65].

Conclusions

While there is a long-standing history acknowledging the existence of human gender diversity, the history of gender-affirming medical care for adolescents, in particular, is relatively brief. Evolving protocols for gender-diverse adolescents, first pioneered in the Netherlands, have been incorporated into clinical practice guidelines and standards of care published by the Endocrine Society and WPATH, respectively, and have been endorsed by major medical and mental health professional societies around the world. Notably, however, while there has been increased acceptance of gender diversity in some parts of the world, transgender adolescents and those who provide them with gender-affirming medical care, particularly in the USA, have been caught in the crosshairs of a culture war, with the risk of preventing access to care that published studies have indicated may be lifesaving. Despite such challenges and barriers to care, currently available evidence supports the benefits of an interdisciplinary model of gender-affirming medical care for transgender adolescents. Further long-term safety and efficacy studies are needed to optimize such care.

Statement of Ethics

Not applicable as this is a historical report and not a report of research.

Conflict of Interest Statement

Jeremi M. Carswell, Ximena Lopez, and Stephen M. Rosenthal declare no conflicts of interest.

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Author Contributions

Jeremi M. Carswell, Ximena Lopez, and Stephen M. Rosenthal contributed equally to the writing of the manuscript. Jeremi Carswell and Ximena Lopez are the co-first authors, and Stephen M. Rosenthal is the senior and corresponding author.

Data Availability Statement

There were no data generated for this report.

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The History of Obesity Research

Robert H. Lustig[a] Ilene Fennoy[b]

[a]Department of Pediatrics, University of California, San Francisco, CA, USA; [b]Department of Pediatrics, Columbia University, New York City, NY, USA

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Abstract
Perhaps the most unexpected development in pediatric endocrinology in the past 50 years has been the recognition of obesity as an endocrine/metabolic disorder rather than a life choice or moral failing. The history of obesity research is disjointed, having followed two separate paths in the 20th century, based on two independent yet overlapping paradigms. Proponents of the "Energy Storage" hypothesis point to data implicating monogenetic disorders, the ventromedial hypothalamus, insulin, cortisol, and the adipocyte itself in the pathogenesis of obesity. Alternatively, proponents of the "Energy Balance" hypothesis point to data implicating increased caloric intake, decreased caloric expenditure, gastrointestinal hormones, and microbiome changes as being critical for obesity. These two separate lines of research merged somewhat with the discovery of leptin in 1994, as leptin established a major hormonal role in weight control. Leptin has explained some of the dichotomy and has proved essential in understanding the importance of developmental programming and epigenetics. However, the mystery of leptin resistance remains unsolved. Despite all our collective knowledge, we appear no closer in solving the obesity puzzle today than we were 50 years ago. © 2022 S. Karger AG, Basel

Introduction

The Venus von Willendorf, a 13-inch bust of an obese woman's torso, sitting in the Natural History Museum of Vienna, carbon dates back to 24,000 BCE (Fig. 1). Obesity has been around for a long time, although in ancient times it was a rare occurrence. Throughout the Middle Ages and the Renaissance, obesity was considered a status symbol of affluence (e.g., Rubenesesque body types). The focus on childhood obesity is much more recent and only gained public attention approximately 40 years ago, when it was noted that a stable childhood obesity prevalence curve morphed into a parabolic one. Currently, 19.7% of American children [1] and 5.7% of European children [2] are obese. Similarly, the number of academic articles on obesity has exhibited a similar parabolic climb over the last 20 years [3].

Despite its increasing incidence, prevalence, and severity, we have limited understanding of what causes obesity and an even poorer understanding of best approaches to management. Perhaps the most blatant example of our confusion is that to this day, we still don't know to what extent, for the vast majority of individuals, obesity is due to a defect in energy storage, which is primarily endocrine in etiology, or due to a defect in energy balance, which is primarily nutritional in etiology. Indeed, in the 20th century, the history of obesity research had taken two divergent paths, with various adherents subscribing

Karger@karger.com
www.karger.com/hrp

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Correspondence to:
Robert H. Lustig, robert.lustig@ucsf.edu

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to one or the other hypothesis. Table 1 provides an integrated chronological timeline of research progress, underscoring proponents of each hypothesis.

The Energy Storage Hypothesis

In exploring the energy storage hypothesis of obesity, genetic and endocrinologic constructs have provided the primary key insights into the determinants of obesity. Organs involved include the brain, the adrenal gland, the pancreas, and the adipocyte itself.

The Ventromedial Hypothalamus and Obesity

The seminal illustration of the energy storage hypothesis is the clinical syndrome of hypothalamic obesity. The first description dates back to 1840, when a 57-year old woman developed massive obesity within a year of her death, and an autopsy demonstrated a tumor at the base of the brain [4]. The notion that obesity could have a neuroendocrine (i.e., either brain or hormone) origin dates back to 1900, when Babinski [5] and Frohlich [6] independently described children who were normal weight until the development of a tumor at the base of the brain, which led to massive obesity that was unresponsive to any intervention. However, both ascribed the obesity to dysfunction of the pituitary. By 1921, Bailey and Brenner [7] showed that stereotactic lesioning of the same area in rats led to massive obesity. In 1937, Harris [8] localized the hypothalamus as the brain area regulating energy metabolism and other hormonal secretions. In 1940, Hetherington and Ranson [9] lesioned the ventromedial hypothalamus (VMH) without damaging the pituitary and recapitulated the same increase in adiposity, and in 1943, Brobeck et al. [10] demonstrated that these animals developed severe hyperphagia, thus postulating (incorrectly) that the VMH was the brain's "satiety center". However, this was disproven in 1975 when Bray and Gallagher [11] demonstrated that even on a calorically restricted diet in-hospital, these patients still gained weight. Rather, in the 1970s, studies in rats by the Bray lab in the USA [12] and Rohner-Jeanrenaud and Jeanrenaud [13, 14] in France showed that either VMH lesions or vagal stimulation increased insulin secretion from the pancreas and resultant hyperphagia, both of which could be blocked by vagotomy. These findings have argued for a VMH-vagus-pancreas-adipose axis that regulates energy storage [15].

Color version available online

Fig. 1. The Venus von Willendorf, a sculpture housed in the Vienna Natural History Museum, carbon dates to 24,000 BCE. Venus von Willendorf by Matthias Kabel: CC-BY-2.5.

Cortisol and Obesity

In 1912, Cushing described his experience with the now-famous "Minnie G." and seven other patients with pituitary basophilic adenoma, "painful" obesity, headache, and hypertension [16]. Subtemporal decompression reversed many of the symptoms (as well as the obesity), for a time, but most of the patients died years later. However, within the next 2 decades, it became clear that many patients with "Cushing's Disease" did not have a pituitary

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Table 1. Chronology of major discoveries in the field of obesity and relationship to origin of obesity hypotheses

Year	Obesity milestone	Author(s)	Relationship to origins of obesity hypotheses
Antiquity	Description of obesity	Hippocrates	
1901	Hypothalamic obesity	Babinski [5], Frohlich [6]	ES[1]
1916	Calories in specific foods	Atwater [59]	EB[2]
1921	Lesioning of VMH results in obesity	Bailey and Brenner [7]	ES
1921	Discovery of insulin	Banting and Best [28]	ES
1922	Hypophysectomy for Cushing's disease	Cushing [16]	ES
1930	Theory of energy balance	Newbergh [60]	EB
1941	Physiologic dissociation of hypothalamus from pituitary	Hetherington et al. [9]	ES
1943	VMH lesions cause hyperphagia	Brobeck et al. [10]	ES
1956	Reduced activity in obese humans	Mayer et al. [66]	ES
1960	High insulin in type 2 diabetes	Yalow and Berson [34]	ES
1964	Weight loss reduces adipocyte size, not number	Hirsch et al. [44, 45]	ES
1973	Parabiosis of *ob/ob* and *db/db* mice	Coleman [108]	ES
1975	Hypothalamic obesity gain weight even when food restricted	Bray and Gallagher [11]	ES
1982	Discovery of Peptide YY_{3-36}	Tatemoto [79]	EB
1986, 1990	Heritability of BMI in twins	Stunkard et al. [52, 53]	ES
1987	Glucagon-like peptide-1 stimulates insulin	Holst et al. [88], Mosjov et al. [89]	EB
1987	Bariatric surgery reverses diabetes	Pories et al. [74]	EB
1990	Insulin stops fat oxidation	Bonadonna and DeFronzo et al. [40]	ES
1990	SGA infants and adult chronic disease, beginning of DOHaD	Barker [48]	ES
1992	Isolation of Exendin-4	Eng et al. [94]	EB
1994	Cloning of leptin	Zhang et al. [109]	ES
1995	Weight loss reduces resting energy expenditure	Leibel et al. [69]	EB
1997	Leptin treatment in leptin deficiency	Farooqi et al. [112]	ES
1997	Congenital leptin deficiency	Montague et al. [110]	ES
1998	Melanocortin-4 receptor mutation	Yeo et al. [56]	ES
1998	Leptin receptor mutation	Clement et al. [111]	ES
1998	PPAR-gamma is a transcriptional regulator of subcutaneous fat	Spiegelman et al. [85]	ES
1999	Recombinant leptin ineffective in adult obesity	Heymsfield et al. [115]	ES
2001	Discovery of ghrelin	Cummings et al. [62]	EB
2001	Dutch Winter Famine research	Roseboom [47]	ES
2004	Discovery of microbiome (fecal transplant)	Bäckhed et al. [99]	EB
2004	Leptin rewires the hypothalamus	Pinto et al. [126]	ES
2005	Liposuction does not improve metabolism	Klein et al. [27]	ES
2006	Peptide YY_{3-36} is a satiety signal	Ballantyne [80]	ES
2007	Leptin extinguishes reward in leptin deficiency	Farooqi et al. [113]	ES
2008	Fat cell number fixed by age 2	Spalding et al. [46]	ES
2009	Lipodystrophy treated with leptin	Mulligan et al. [114]	ES
2009	GWAS studies show 36 loci associated with body weight	Loos [58]	ES
2013	Gut microbiome and leptin resistance	Schéle et al. [124]	ES and EB
2015	Dietary fat reduction resulted in reduced body fat	Hall et al. [71]	EB

[1] ES, energy storage. [2] EB, energy balance.

tumor but rather an adrenal adenoma [17], and that unilateral adrenalectomy would reverse the obesity, suggesting an adrenal hormonal etiology. By 1936, the Kendall lab had isolated cortisone from bovine adrenal glands [18], and by 1946, Sarett had succeeded in synthesizing cortisol for pharmaceutical use [19]. While cortisol turned out to be a "wonder drug" for various inflammatory diseases, its side-effects were undeniable, especially weight gain [20].

Numerous studies of adrenal function in general obesity have demonstrated increased absolute daily urinary cortisol excretion; however, when corrected for body mass index or fat mass, these differences are mitigated [21]. Further investigation, using transgenic mice bearing a mutation in the gene encoding 11β-hydroxysteroid dehydrogenase-1, which prevents the conversion of the active hormone cortisol to the inactive precursor cortisone,

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by the Flier lab in 2001, demonstrated an increase in visceral obesity and metabolic syndrome [22]. In another set of transgenic studies, the Zukowska lab in 2007 showed that acute adrenergic activation of the visceral adipose tissue depot resulted in lipolysis, while chronic activation resulted in lipogenesis, due to the adrenergic-blocking effects of the co-localized Neuropeptide Y [23].

In clinical studies, increased stress and HPA axis activity have been noted in patients with visceral adiposity [24, 25]. These findings support a role for stress, chronic adrenergic activation, and cortisol in the growth of the visceral fat depot, exclusive of the subcutaneous fat depot, and with an increased risk for chronic metabolic disease. Conversely, in 2002, the DeFronzo lab showed that thiazolidinediones (TZDs), by binding to the peroxisome proliferator-activated receptor-gamma (PPARγ) increase subcutaneous fat development but not visceral fat, and cause weight gain yet improve insulin sensitivity and reduce risk for metabolic syndrome [26]. Apparently, the converse is also true, as Klein et al. [27] demonstrated in 2005 that liposuction of subcutaneous fat only did nothing to improve the metabolic dysfunction of obese subjects.

Insulin and Obesity

Insulin is a prerequisite for energy storage in adipose tissue. It has long been known that type 1 diabetics lose significant weight and fat mass before succumbing to diabetic ketoacidosis. In 1921, Banting et al. [28] discovered insulin; shortly thereafter, patients with type 1 diabetes worldwide started receiving exogenous insulin injections, and it became apparent that recipients rapidly increased their adiposity by shunting glucose and lipid into adipocytes [29]. Furthermore, studies of patients who manifested increased endogenous insulin release (e.g., congenital hyperinsulinism, Beckwith-Wiedemann syndrome, insulinoma) also had increased adiposity [30, 31].

In 1939, Himsworth [32] first postulated the concept of insulin resistance; this was borne out in 1951 when Bornstein and Lawrence [33] first measured insulin levels in patients with type 2 diabetes. In 1959, Yalow and Berson [34], in developing the concept and procedures for the radioimmunoassay, showed consistent hyperinsulinemia in those with type 2 diabetes. In 1983, Reaven et al. [35] demonstrated that the majority of, but not all, obese persons without diabetes also had increased fasting insulin levels; those that did had associated insulin resistance [36], and that they manifested the cluster of signs ("diseases") which he termed "Syndrome X," but "metabolic syndrome" was the term that stuck. However, for decades, this paradox of high insulin levels and low insulin effect was explained by the postulate that obesity induced insulin resistance. Furthermore, Knowler et al. [37] showed in 2002 that weight loss improved insulin sensitivity and reduced risk for disease.

More recent research argues that insulin is a primary driver of weight gain. Johnson et al. have demonstrated that transgenic animals deficient in insulin secretion gain less adipose tissue and manifest increased longevity [38]. In humans, the Ludwig lab showed in 2008 that the Quebecois, who exhibit an increased insulin release in response to glucose, manifest increased weight gain in response to a high-carbohydrate diet [39]. Bonadonna et al. [40] showed that insulin inhibits fatty acid beta-oxidation, thus preventing energy utilization. **Robert Lustig** et al. [41, 42] suppressed insulin secretion using octreotide and demonstrated weight loss, first in 1999 in patients with hypothalamic obesity, and then in a sub-cohort of obese adults in 2006. These and other revelations have supported the carbohydrate-insulin hypothesis of obesity [43]; that is, increased carbohydrate diets stimulate insulin release, resulting in energy storage and increasing adiposity.

The Adipocyte and Obesity

Many other hormones affect adipocyte growth (e.g., estrogens, androgens, thyroid hormone), but first those adipocytes have to develop – and once they do, they don't go away. In 1964, Hirsch and Goldrick [44, 45] demonstrated that weight loss reduces fat cell size but not fat cell number, suggesting that obese individuals have aberrant adipose tissue development. Spalding et al. [46] in 2008 showed that adipose tissue number was set by age 2 years in humans, putting the focus on the fetal and neonatal period. Indeed, documentation of the relationship of small for gestational age with adult obesity and cardiovascular disease started with studies of the Dutch Hunger Winter during World War II and its aftermath. Data on adults born to women exposed to rations of less than 1,000 kcal/day during different periods of gestation identified small size at birth for third trimester exposure with abnormalities of glucose tolerance as adults, while first trimester exposure resulted in increased size at birth with atherogenic lipogenic profile as adults [47]. These studies supported Barker's 1990 postulate of the Developmental Origins of Health and Disease (DOHaD) [48]. We now have data that the *in utero* environment modulates the risk of obesity and metabolic disease into childhood and adulthood [49].

The DOHaD paradigm applies to environmental chemical exposures, including obesogens, which can also

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lead to obesity later in life, and even across generations [50]. For example, the U.S. government in 1972 banned the insecticide dichlorodiphenyltrichloroethane (DDT), composed of o,p′-DDT and p,p′-DDT, of which the latter is metabolized to the long-acting p,p′-DDE, which was shown in 2021 to be associated with obesity and earlier age of menarche in the grandchildren of the exposed grandmothers [51]. These findings demonstrate that there is a window of neural, chemical, and hormonal vulnerability during the fetal and neonatal period, during which risk for obesity can be programmed.

Genetics and Obesity

In 1975, Stunkard et al. [52, 53] examined the variance in BMI in mono- and dizygotic twins and estimated the heritability of obesity at 40–70%. Further strong evidence of the heritability of BMI came from a study of identical twins separated at or near birth and brought up in different environments. The study demonstrated that as adults, BMI was highly correlated between identical twins but showed little correlation with that of their adoptive parents or siblings. In the mid-1990s, the melanocortin system, consisting of the pro-hormone proopiomelanocortin (POMC) and its metabolites (α-melanocyte stimulating hormone [α-MSH], β-MSH, γ-MSH, and ACTH), as well as the five G-protein melanocortin receptors and their antagonists (e.g., Agouti-related peptide [AgRP]), was associated with feeding behavior and energy homeostasis [54]. The system acts as a key mediator of a variety of physiologic functions, including adrenal growth and hormone development, erectile responses, natriuresis, melanogenesis, as well as energy homeostasis [55]. However, despite the physiologic significance of this system and the recognition of its derivation from the *POMC* gene (as well as the identification of numerous other genes associated with obesity), these genetic loci have had only a limited impact on the epidemic of obesity due to the small numbers of individuals affected by single gene defects. The melanocortin-4 receptor (MC_4R) is of greatest epidemiologic significance, being involved in approximately 2.5% of those morbidly obese [56]; however, all the other monogenetic disorders in the energy balance pathway combined account for less than another 1%. Furthermore, GWAS studies suggest that a minority of weight gain is attributable to other genetic loci. The *FTO* gene, which encodes alpha-ketoglutarate dependent dioxygenase, is the most prevalent genetic association found thus far (in 14% of children) only accounts for 3.3 kg in extra weight [57]. While a total of 39 different genes demonstrate linkage with obesity, their collective contribution to the prevalence of obesity is quite small [58]. Nevertheless, their recognition has led to an enhanced understanding of the physiology of obesity with the interaction of peripheral factors and central factors controlling appetite and energy metabolism.

The Energy Balance Hypothesis

The energy balance hypothesis has been around for just as long, and encompasses both control of energy intake and rates of energy expenditure, including thermogenesis. Relevant organs include the liver, muscles, and GI tract.

Energy Intake and Obesity

The conservation of energy by the human body was first posited by Atwater [59]. He related the unit of combustion, the "calorie", to the nutrient value of foods, and demonstrated that each calorie consumed was either stored, burned, or excreted. Newburgh and Johnston [60] in 1930 proposed that obesity was a simple matter of excessive intake relative to energy expended. He proposed that "All obese persons are, alike in at least one fundamental respect – they literally overeat." This hypothesis has become a central tenet of obesity management, leading to the focus on dietary restriction as the primary intervention [61].

Cummings et al. [62] pursued the idea of obesity as an endocrine problem identifying ghrelin, its pre-prandial rise, and role in meal initiation. Ghrelin levels are elevated in patients with Prader-Willi syndrome [63] and low in patients with simple obesity [64], confounding the idea that abnormalities in ghrelin explained general obesity. To date, ghrelin remains one of a limited number of identified orexigenic hormones, but one without a disease attached to its excess or deficit.

Energy Expenditure and Obesity

The notion that energy expenditure might be dysfunctional in obese individuals was codified by Mayer [65], who in 1953 noted that obese mice were more sedentary than controls; a finding he expanded to humans by 1956 [66], suggesting that "calories out" played a major role in obesity. This started the "exercise" craze for weight loss in an attempt to balance the "calories in" part of the equation.

However, implementation of this approach to obesity management has demonstrated that weight loss and weight maintenance are difficult to achieve [67, 68]. Metabolic adaptation to change from baseline weight through changes in energy expenditure during the process of weight loss or gain was demonstrated by **Rudolph Leibel**

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et al. [69] and shown to persist during weight maintenance by Camps et al. [70].

Several approaches to understanding metabolic adaptation have been undertaken. One effort has focused on the value of carbohydrates versus fat or protein for the adaptive response. The questions remain, is a calorie a calorie? And which is better – low fat or low carbohydrate diets? Numerous studies have explored these questions. In a 2015 in-patient metabolic balance study, Hall et al. [71] demonstrated that a 30% caloric restriction with stable protein but decreased carbohydrate content of the diet resulted in increased oxidation of fat but decreased carbohydrate oxidation and no appreciable change in body fat; whereas decreasing the fat content of the diet resulted in decreased body fat, suggesting that dietary fat was a greater contributor to body fat because of its calories. These findings were supported by a systematic review and meta-analysis of randomized control trials [72].

Nevertheless, the proponents of the energy storage hypothesis have argued that obesity is the result of high-carbohydrate diets, which stimulate insulin release, driving fat into cells for storage, decreasing lipolysis, and producing obesity [61]. As a result, they argue that the emphasis should be on diet composition rather than calorie counting and energy balance, with the hypothesis that the etiology of obesity is fundamentally an endocrine problem affecting metabolism [73].

GI Hormones and Obesity

Bariatric surgery as a modality for severe obesity was introduced as early as 1950. Pories et al. [74] were able to demonstrate in 1987 not only weight loss but also control of type 2 diabetes by this procedure, and, in 1992 documented, long-term diabetes remission with up to 10-year follow-up [75]. Furthermore, improved control of diabetes occurred within days after bariatric surgery and therefore was not likely due to weight loss [76], making the initial hypotheses of the metabolic benefit of this procedure due to restriction [77] and malabsorption [78] less likely as the sole mechanism.

Exploration of mechanisms that might explain this rapid change in diabetes control after bariatric surgery involved analysis of the effects of the procedure on gut hormone secretion including peptide YY (PPY) and glucagon-like peptide 1 (GLP-1). PYY had been initially identified in porcine intestine in 1980 and shown to inhibit exocrine pancreatic secretions [79]. Secreted by the L-cells of the intestine, PYY is thought to exert its primary effect by acting on the central nervous system to induce satiety by binding to the Y_2 receptors on POMC neurons in the VMH [80]. Obese subjects appear to have reduced PYY secretion and decreased sense of satiety [81]. After bypass surgery, baseline PYY levels decrease, yet respond better to stimulation by food [82]. Though PYY is clearly a satiety hormone, its role in obesity management remains an area of ongoing investigation [83, 84].

Glucagon-like peptide-1 (GLP-1), a 31-amino acid polypeptide secreted primarily by the L-cells of the intestine [85], is a splice product of proglucagon [86, 87], which was shown in 1987 to be a potent stimulator of insulin release [88, 89]. Nauck et al. [90] showed the GLP-1-induced insulin response to be glucose-dependent and absent below a glucose threshold of 4.3 mM. As with PYY, GLP-1 acts both centrally [91] and peripherally [92] to inhibit food intake. GLP-1 is secreted in response to nutrients [93] with a short half-life of activity due to cleavage by dipeptidyl peptidase-4 (DPP-4) and renal clearance. However, with the isolation of Exendin-4 (a long-acting analog of GLP-1) from the Gila monster [94], a new world of therapeutics (first for diabetes, then for obesity) began with GLP-1 receptor agonist therapy [95].

The Gut Microbiome and Obesity

The gastrointestinal tract is home to trillions of microorganisms collectively known as the microbiome [96]. Differences in the microbial populations are noted between normal weight and obese individuals [97], with less microbial diversity described in those with obesity [98]; however, it is still not clear whether this is a cause or effect. The Gordon lab was able to show that germ-free mice receiving a fecal microbial transplant (FMT) from conventional mice gained weight despite increased energy expenditure and decreased energy consumption [99]. By transplanting microbiota from genetically obese *ob/ob* mice into germ-free mice, they were able to demonstrate a 2% increase in energy deposition over calories actually consumed. As a result, they hypothesized that the microbiota of obese animals might more efficiently extract energy [100]. Several investigators have demonstrated changes in the microbiome paralleling changes in the diet [101, 102], suggesting that one way diet affects obesity is by altering the microbiome. Thus, the animal model has provided direct evidence that a "predisposed" microbiome might increase the energy intake of individuals with obesity. However, data from humans have been inconsistent [103].

Dietary efforts to manipulate this system have focused on prebiotics, "a nondigestible food ingredient that beneficially affects the host by selectively stimulating the growth and/or activity of one or a limited number of bac-

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teria in the colon, and thus improves host health" [104]. For instance, in 2006 Cani et al. [105] administered the indigestible carbohydrate oligofructose to animals, resulting in improved insulin sensitivity, and to humans, resulting in increased satiety and decreased energy intake [106], possibly by altering GI hormones. Prebiotics, probiotics, and postbiotics remain an active area of investigation in the treatment of obesity [107].

Putting It All Together: The Leptin Era

Throughout the 20th century, these two investigative paradigms seemed destined to continue to disagree about the etiology and pathogenesis of obesity. But two mice solved the conundrum that is obesity – or so one thought. Coleman was the first to postulate hormonal feedback from the adipose tissue to the brain. In 1973, he joined the circulations of an *ob/ob* and a *db/db* mouse in a parabiosis experiment; the *ob* mouse lost weight, while the *db* mouse did not [108]. This suggested a circulating factor present in the *db* mouse and a functional receptor present in the *ob* mouse. Positional cloning by Friedman's lab led in 1994 to the identification of the adipocyte hormone leptin [109].

Leptin Clinical Studies

In 1997, the O'Rahilly lab identified the first leptin-deficient child [110], and in 1998, the first leptin receptor-deficient patient was identified by Clement et al. [111]. Farooqi et al. [112, 113] showed in 1999 that leptin therapy worked well in promoting weight loss and in reducing appetite and reward in children with congenital leptin deficiency, and Mulligan et al. [114] in 2009 showed similar results in adult patients with lipodystrophy (who also manifest leptin deficiency). But unfortunately, leptin proved to be ineffective in generalized obesity [115] because these patients are leptin resistant.

Leptin Resistance

The first clue to the pathogenesis of leptin resistance was gleaned in 1995 by **Leibel** et al. [69], who showed that obese patients who lost weight also reduced their energy expenditure, as they became leptin deficient in addition to being leptin resistant. Thereafter, Levine et al. [116] demonstrated one reason why this occurs; patients who gain weight easily have decreased levels of nonexercise activity thermogenesis (NEAT; otherwise known as fidgeting) due to their leptin resistance. However, Rosenbaum et al. [117] performed a seminal experiment which showed that in response to weight loss, obese patients regained sensitivity in response to exogenous leptin injection. These findings suggested that some factor was reversibly antagonizing leptin action in the obese patient.

That factor was identified in 2001, when Niswender and Schwartz [118] documented overlap and crosstalk among insulin, the insulin receptor, and the leptin receptor in the hypothalamic POMC neuron. **Lustig** et al. [119] demonstrated increased leptin sensitivity upon insulin suppression. Also, the Bruning lab [120] and Nazarians-Armavil et al. [121] demonstrated that hyperinsulinemia is at least a cause, if not the only cause, of leptin resistance. The question is why?

Leptin is a necessary signal to the VMH for the initiation of high-energy processes such as puberty and pregnancy [122]. Indeed, both puberty and pregnancy are insulin-resistant states; leptin levels increase acutely; in adulthood or post-partum, insulin levels fall, weight stabilizes or is lost, and leptin levels return toward the baseline state. Insulin antagonism of leptin signal transduction is likely an integral control mechanism to insure reproductive competence. If leptin signaling could not be modulated, the weight accrual required for reproductive competency during puberty and pregnancy would be compromised [123].

The gut microbiome may also play a role in leptin resistance. In an experiment using only mice otherwise resistant to obesity, Schéle et al. [124] compared mice raised germ-free to conventionally raised mice. The conventionally raised mice had decreased expression of GLP-1 and brain-derived neurotropic factor (BDNF) in both the hypothalamus and brain stem, as well as decreased expression of anorexigenic peptides POMC and CART (cocaine- and amphetamine-regulated transcript), and increased expression of the orexigenic peptides NPY and AgRP in the hypothalamus. Furthermore, the conventionally raised mice had inherent leptin resistance, as leptin administration caused less suppression of NPY and AgRP and less weight loss than in the germ-free mice, a clear signal that the gut microbiota influences central feeding mechanisms.

Leptin and DOHaD

Leptin also exerts effects in the prenatal period. Leptin-deficient mice (*ob/ob*) exhibit maldevelopment of hypothalamic architecture, with aberrant projections of neurons from the arcuate nucleus (the site of leptin receptors) to the paraventricular nucleus (the site of the melanocortin-4 receptors) [125]. However, a single leptin injection at birth can restore normal hypothalamic development and neurotransmission [126]. This effect of neonatal

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leptin is also seen in a rat model of maternal undernutrition. Offspring of pregnant rats placed on food restriction during gestation are small for gestational age, insulin resistant, and leptin deficient at birth. However, with adequate nutrition after the neonatal period, these animals become obese as adults, particularly when placed on high-fat chow after weaning [127], suggesting that the neonatal leptin overrode a developmental programming signal for future obesity.

Conclusions

Despite the knowledge of the insulin-leptin connection, and despite multiple efforts of diet, pharmacotherapy, and surgery to promote weight loss, obesity, insulin resistance, and chronic metabolic disease continue to predominate in the population. Only 12% of adults are metabolically healthy [128], and obesity prevalence and severity continue to increase in children, occurring earlier and earlier [129]. Genetics can increase predisposition to obesity but do not explain this health care debacle. Whether this is due to processed food, reduced activity, stress, addiction, mitochondrial dysfunction, obesogens, developmental programming, epigenetics, microbial dysbiosis, or a combination thereof, remains unclear. One hypothesis is that obesity is a syndrome with different patients manifesting different etiologies for their obesity, and therefore likely responding to different therapies. But what is clear is that none of these etiologies are the patient's fault – no one chooses to be obese, especially not children. Obesity and its overlapping disease entities are not a personal health issue, but rather a public health crisis, and will ultimately require a rational public health response.

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Statement of Ethics

Dr. Lustig and Dr. Fennoy state that this work is original, unbiased, and not a work for hire. They also state that this manuscript is not under review at any other journal.

Conflict of Interest Statement

Dr. Lustig and Dr. Fennoy declare no financial or material conflict of interest with respect to this manuscript.

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There were no data generated for this report, only historical references.

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From: [redacted]@ucsf.edu>
Sent: Tuesday, November 29, 2022 5:57 PM PST
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
CC: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Major backlog for CAGC new patient referrals

Thank you for the update!

From: [redacted]@ucsf.edu>
Date: Tuesday, November 15, 2022 at 1:50 PM
To: [redacted]@ucsf.edu>, [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: Major backlog for CAGC new patient referrals

Hi [redacted],

We are in the process of confirming the funds flo through the FPO, which is the last step before an offer letter will go out. I have also sent a note to [redacted] about this so that he knows we are still intending to move forward with him.
I am so sorry for how long this has taken.

Thank you,

[redacted] LMFT
Service Line Director Behavioral Health
[redacted]@ucsf.edu
C: [redacted]

Administrative Assistant
[redacted]
[redacted]@ucsf.edu

UCSF Benioff Children's Hospitals

From: [redacted]@ucsf.edu>
Sent: Wednesday, November 9, 2022 12:29 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: FW: Major backlog for CAGC new patient referrals

Dear [redacted] and [redacted]

I hope that you are well!
I am writing on behalf of our child and adolescent gender team with concern about the long delay in completing the hiring process for our preferred psychologist applicant. Would it be possible to please provide a status update – we are worried we may lose that candidate given the duration of the hiring process. Given the current dire situation of high need for mental health support for our patients, we are hoping to hear an update soon

Kind regards,
[redacted]

[redacted], MD, MHSc
Pronouns: she/her/hers
Selna L. Kaplan Chair Distinguished Professorship in Pediatric Endocrinology/Diabetes
Professor of Pediatrics
Chief, Division of Pediatric Endocrinology and Diabetes
University of California, San Francisco
Department of Pediatrics
Division of Pediatric Endocrinology
Mission Hall
550 16th St., 4th Floor, Box 0434
San Francisco, CA 94143
Tel: (415) 476-3310
Fax: (415) 476-5356
For FedEx deliveries, please use 94158
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From: [redacted]@ucsf.edu>
Date: Friday, November 4, 2022 at 5:07 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>, [redacted]@ucsf.edu>, [redacted]
<[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>, [redacted]@ucsf.edu>, [redacted], [redacted]
<[redacted]@ucsf.edu>, [redacted]@ucsf.edu> [redacted]
<[redacted]@ucsf.edu>
Subject: RE: Major backlog for CAGC new patient referrals

Steve,

Adding [redacted] who I'm hoping can provide an update related to the CAGC psychologist hire.

Thanks,

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, November 04, 2022 5:03 PM
To: [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted], [redacted]
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>;
[redacted]@ucsf.edu>
Subject: Re: Major backlog for CAGC new patient referrals

Hi [redacted],

It's my understanding that capacity is currently maxed out for medical providers in the CAGC (including Adolescent Medicine, but I'll defer to [redacted] cc'd here, who can speak for himself as well as the other 2 Adolescent Med providers--[redacted] and [redacted]).

Rather than set up a zoom meeting now, I think the best solution, now that I see from [redacted] that the new CAGC APP has been approved, would be to get that position posted and filled as soon as possible. If that person's primary clinical focus is seeing new CAGC patients, that will make a major difference.

However, of course, the limiting capacity will then be mental health support—which we require for all new CAGC patients. The recent addition of two Child and Adolescent Psychiatrists has certainly helped, but we have yet to have the new CAGC psychologist position filled (vacant now for 13 months!). I believe you are aware of the long delays in completing the hiring process for our preferred psychologist applicant. We were told that person would be on-boarded in November, but we have gotten no response to our requests for a status update from Behavioral Health, and I fear we may lose that candidate. It might be helpful if you are able to intervene.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, November 4, 2022 4:44 PM

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To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Major backlog for CAGC new patient referrals

Hi Steve- I agree we have reached a point where the need far outpaces the access to care for gender diverse youth – hiring the new PNP, bring [redacted] on faculty in Sept, and sending an offer to [redacted] are part of the plan – in the interim [redacted] has switched to seeing more gender patients than general endo – and we have some new adolescent med folks who could perhaps ramp up their clinic time in the interim? Im not sure what else we can do with the faculty we currently have… i.e. who has the capacity to see more patients than they already are… happy to have a call to discuss- I'll ask [redacted] to set one up – who would you like to be on ?

[redacted]

From: [redacted]@ucsf.edu>
Date: Friday, November 4, 2022 at 4:38 PM
To: [redacted]@ucsf.edu>, Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>, [redacted]@ucsf.edu>, [redacted] <[redacted]@ucsf.edu>, [redacted]@ucsf.edu>
Subject: RE: Major backlog for CAGC new patient referrals

All,

The CAGC APP received FPO approval and is awaiting approval by the Labor Management Review committee before being pushed through to HR for posting. I will update the group as soon as it's posted, hopefully within the next week.

Thanks,

[redacted]

From: [redacted]@ucsf.edu>
Sent: Friday, November 04, 2022 4:35 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Major backlog for CAGC new patient referrals

Hi Steve,

Thank you for advocating for these patients! I included [redacted] in case he has additional updates on the new CAGC PNP hire. We continue to have patient demand for additional mental health and medical staffing. We should also be receiving additional nursing FTE when we add medical providers.

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Date: Friday, November 4, 2022 at 5:27 PM
To: [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>, [redacted]@ucsf.edu>, [redacted]@ucsf.edu>, [redacted], [redacted] <[redacted]@ucsf.edu>
Subject: Major backlog for CAGC new patient referrals

Hi [redacted],

I just had a meeting with clinic schedulers for the CAGC, including [redacted] from the Call Center (for Internal Referrals) and [redacted] from the Access Center (for External Referrals). I was shocked to learn that there are currently approximately 150 patients awaiting new CAGC appointments from the Access Center and an additional 80 patients awaiting new CAGC appointments from the Call Center = **230 patients currently waiting for a new patient CAGC appointment (!!!)** Some of our CAGC medical providers will be opening their CAGC templates for 2023, but this will only put a minor dent in addressing the need.

Can we set up a zoom to strategize?

Thanks,

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Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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Hormone Research in Paediatrics

Historical Review

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The Evolution of Adolescent Gender-Affirming Care: An Historical Perspective

Jeremi M. Carswell[a] Ximena Lopez[b] Stephen M. Rosenthal[c]

[a]Endocrinology Division, Department of Pediatrics, Boston Children's Hospital, Boston, MA, USA; [b]Division of Pediatric Endocrinology, Department of Pediatrics, Southwestern Medical Center, University of Texas, Dallas, TX, USA; [c]Division of Pediatric Endocrinology, Department of Pediatrics, Benioff Children's Hospital, University of California San Francisco, San Francisco, CA, USA

Keywords
Transgender · Gender-affirming care · Gender identity · Biology of gender · Adolescence · Pubertal blockers · Gender-affirming hormones

Abstract
While individuals have demonstrated gender diversity throughout history, the use of medication and/or surgery to bring a person's physical sex characteristics into alignment with their gender identity is relatively recent, with origins in the first half of the 20th century. Adolescent gender-affirming care, however, did not emerge until the late 20th century and has been built upon pioneering work from the Netherlands, first published in 1998. Since that time, evolving protocols for gender-diverse adolescents have been incorporated into clinical practice guidelines and standards of care published by the Endocrine Society and World Professional Association for Transgender Health, respectively, and have been endorsed by major medical and mental health professional societies around the world. In addition, in recent decades, evidence has continued to emerge supporting the concept that gender identity is not simply a psychosocial construct but likely reflects a complex interplay of biological, environmental, and cultural factors. Notably, however, while there has been increased acceptance of gender diversity in some parts of the world, transgender adolescents and those who provide them with gender-affirming medical care, particularly in the USA, have been caught in the crosshairs of a culture war, with the risk of preventing access to care that published studies have indicated may be lifesaving. Despite such challenges and barriers to care, currently available evidence supports the benefits of an interdisciplinary model of gender-affirming medical care for transgender/gender-diverse adolescents. Further long-term safety and efficacy studies are needed to optimize such care.

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Introduction

The relatively recent recognition of diversity of "gender identity" – one's inner sense of self as male or female or somewhere on the gender spectrum – in the current culture belies its long-standing presence in cultures diverse and ancient. "Transgender" (sometimes referred to as "gender incongruence") is defined as a marked and persistent incongruence between an individual's experienced gender and their sex designated at birth. Transgender is often used as an umbrella term to encompass all gender identities that are not the same as the birth-assigned gender (typically based on the sex designated at

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www.karger.com/hrp

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Correspondence to:
Stephen M. Rosenthal, stephen.rosenthal@ucsf.edu

Karger

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birth) but may also be used specifically for a binary gender identification.

As our understanding of gender has been evolving over time, so has the language used to describe gender. Throughout this manuscript, the authors have primarily used the terminology of the present day, though historical descriptions will contain language that is clearly outdated. We have chosen to use these terms only to maintain the historical perspective in this context.

The Historic and Cultural Diversity of Gender

Though it may seem that transgender as a concept is a recent phenomenon, there are both ancient and diverse examples that underscore the understanding that humans have experienced gender as beyond the set of cultural norms assigned to them based on their genitals. In Greek and Roman mythology, there are legends of deities who defy traditional concepts of gender; the most famous may be Hermaphroditus, a son born of Hermes and Aphrodite. When the nymph Salmacis fell in love with him, their forms became merged, with the god depicted as having male genitalia with breasts and a more feminine body shape [1, 2]. Norse mythology gives us the notorious shape and sex shifting Loki, who was known for his trickery, appearing at times in a female form when it suited his purpose [1]. Several Indigenous North American tribes have long-standing recognition and language for gender and/or sexual minority-identified individuals that often signified a third gender, or a combination of male and female. Though the designation and roles varied among tribes, the term "two-spirit" was coined in 1990 during the international LGBT Native American Gathering and attributed to Elder Maya Laramee [3, 4]. This term is not specific to any one tribe or any one group of individuals but encompasses any indigenous member with gender-diverse identification or same-sex attraction.

Biological Underpinnings of Gender Identity

John Money, a New Zealand psychologist and faculty member in pediatrics at Johns Hopkins University beginning in the early 1950s, and co-founder of the Gender Identity Clinic at that university, promoted the concept that gender identity was influenced by "social learning and memory" in conjunction with biological factors [5]. However, a widely publicized case described in a book by John Colapinto published in 2000 lends strong support to the concept that gender identity is not primarily learned [6]. This book focused on a failed circumcision in an 8-month-old male resulting in loss of the penis, leading Money to advise the family to castrate the infant and raise him as a girl [6]. The child never accepted a female gender identity, became severely depressed, and changed gender to male during adolescence. He later committed suicide [6]. In subsequent years, evidence in support of biological underpinnings to gender identity development has continued to emerge, derived primarily from three biomedical disciplines: genetics, endocrinology, and neurobiology [7].

Starting in the late 1970s, heritability of being transgender was suggested from studies describing concordance of gender identity in monozygotic twin pairs and in father-son and brother-sister pairs [8, 9]. In the largest twin study evaluating gender identity, in which at least one member of a twin pair was transgender, there was a much greater likelihood that the other member of the twin pair was also transgender if they were identical versus nonidentical (but same sex) twins [10]. Attempts to identify polymorphisms in candidate genes that might be more prevalent in transgender versus cisgender individuals have been inconsistent. In particular, a 2009 study from Japan did not find any significant associations of transsexualism with polymorphisms in five candidate genes (encoding the androgen receptor, CYP19, ER-alpha, ER-beta, and the progesterone receptor) [11]. However, a 2019 study in 380 transgender women and 344 cisgender male controls demonstrated an over-representation of several allele combinations involving the androgen receptor in transgender women [12]. A subsequent study using whole-exome sequencing in a relatively small number of transgender males (n = 13) and transgender females (n = 17) demonstrated 21 variants in 19 genes that were associated with previously described estrogen receptor-activated pathways of sexually dimorphic brain development [13]. An association between polymorphisms in the estrogen receptor alpha gene promoter and a transgender male identity has also been reported [14].

The vast majority of transgender individuals do not have an intersex condition or any associated abnormality in sex steroid production or responsiveness [7]. However, studies in a variety of intersex conditions have informed our understanding of the potential role of hormones, particularly prenatal and early postnatal androgens, in gender identity development [7]. For example, several studies of 46,XX individuals with virilizing congenital adrenal hyperplasia caused by 21-hydroxylase deficiency demonstrated a greater prevalence of a transgender identity out-

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come (female to male) compared to the general population [15–17]. One such study published in 2006 demonstrated a relationship between severity of congenital adrenal hyperplasia and gender identity outcome, where 7% of patients with the severe salt-wasting form had gender dysphoria or a male gender identity, while no gender dysphoria was seen in any of the less severely affected individuals [16]. Studies in a variety of other hormonal and nonhormonal intersex conditions support a role of prenatal and/or postnatal androgens in gender identity development [7]. However, in 2011, a case report in a 46,XY individual with complete androgen insensitivity and a male gender identity challenged the concept that androgen receptor signaling is required for male gender identity development [18].

Neuroimaging studies that aim to understand the neurobiology of gender identity indicate that some sexually dimorphic brain structures are more closely aligned with gender identity than with physical sex characteristics in transgender adults prior to treatment with gender-affirming hormones [19–21]. A similar trend was reported in studies of gray matter in youth with gender dysphoria [22]. In 2021, an MRI study in transgender adults, also prior to treatment with gender-affirming sex hormones, found that transgender people have a unique brain phenotype "rather than being merely shifted towards either end of the male-female spectrum" [23]. Notably, in both transgender adolescents and adults, several functional brain studies looking at responses to odorous compounds or mental rotation tasks demonstrated that patterns typically observed to be sexually dimorphic were more closely aligned with gender identity than with physical sex characteristics, even before treatment with gender-affirming sex hormones [24–26].

History of Modern Gender-Affirming Medical Treatment

Though individuals have demonstrated gender diversity throughout history, the use of medication and/or surgery is relatively recent with origins in Germany in the first half of the 20th century and is credited to the pioneering work of Magnus Hirschfeld. The institution he founded, "Institut für Sexualwissenschaft (the Institute for Sexual Science)" in Berlin (1922), paved the way for the use of hormones and surgery [27]. In Hirschfeld's study of what he named "sexual intermediaries," he recognized that people may be born with a nature contrary to their assigned gender. In cases where the desire to live as the opposite sex was strong, he thought science ought to provide a means of transition. Innovative for his time, he argued that a person may be born with characteristics that did not fit into heterosexual or binary categories and supported the idea that a "third sex" existed naturally [27]. The first documented case of genital surgery was performed at the institute on Dorchen Richter in 1922 with orchiectomy and then 1931 with penectomy and vaginoplasty [27, 28]. Notable patients, including Lili Elbe (born Einar Wegener), the patient on whom the movie "The Danish Girl" is based, underwent a series of operations including transplant of both ovaries and a uterus [29].

This clinic would be a century old if it had not fallen victim to Nazi ideology and Hitler's mission to rid Germany of Lebensunwertes Leben, or "lives unworthy of living." What began as a sterilization program ultimately led to the extermination of millions of Jews, Gypsies, Soviet, and Polish citizens, as well as homosexuals and transgender people. When the Nazis came for the institute in 1933, Hirschfeld had fled to France. Troops swarmed the building and created a bonfire that engulfed more than 20,000 of his books, some of them rare copies that had helped provide a history for transgender people [27].

In the 1950s, German-American physician Harry Benjamin (1885–1986) introduced the term "transsexuality," defining a "transsexual" person as someone who identifies in opposition to their "biological sex" [30]. Harry Benjamin graduated cum laude from medical school in Tübingen, Germany, in 1912. He moved to New York City in 1914 to study tuberculosis, but over time, he became known as a geriatrician, endocrinologist, and sexologist [31]. He did not treat his first transgender patient until he was in his 60s, and his colleagues described him as follows: "Being a true physician, Benjamin treated all these patients as people and by respectfully listening to each individual voice, he learned from them what gender dysphoria was about" [32]. Notably, he did not describe "transsexualism" as a psychological problem, but as a biological condition that could be treated with hormone or surgical therapy [31]. He treated over 1,500 patients, and in 1966, he published the first medical textbook in this field, "The Transsexual Phenomenon" [33]. His work was very influential, and he became known as "The Father of Transsexualism" [31, 32].

Following World War II, gender-affirming treatment in the USA was limited to wealthy patients who could afford to travel to Europe, though they did so at great risk given the laws in several states outlawing "cross-dressing" [34]. Christine Jorgensen (1926–1989) brought visibility

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to transgender patients, having undergone medical and surgical transition in Europe after she had served time in the US military as a male [35].

Influenced by Dr. Benjamin Harris' "The Transsexual Phenomenon" [33], Johns Hopkins Hospital in Baltimore became the first academic institution in the USA to offer gender-affirming surgery [36]. Soon after, at least another 8 academic institutions opened transgender programs throughout the 1960–1970s (University of Minnesota, University of Washington, Northwestern/Cook County Health in Chicago, Stanford University, Cleveland Clinic, University of Colorado, Baptist Medical Center in Oklahoma City, and Washington University in St. Louis) [37].

Toward the end of the 1970s, however, most transgender programs closed access to new patients. These closures were done quietly out of public view, and the causes were often not disclosed [37]. At Johns Hopkins Hospital, Paul McHugh became the Chair of Psychiatry in 1975. From the moment he was hired, McHugh openly stated he intended to stop gender-affirming surgery at this hospital [38]. Under his leadership, another Johns Hopkins psychiatrist, Dr. Jon Meyer, published a study of 50 patients which concluded that gender-affirming surgery did not provide "objective" benefit for transgender individuals [39]. This publication led to the sudden closure of the clinic in 1979 [36]. Interestingly, John Money, who believed that gender could be learned and who co-founded the Johns Hopkins gender clinic, publicly expressed opposition to Meyer's conclusions of his study [36].

The program at the Baptist Medical Center in Oklahoma City had been functioning since 1973. However, in 1977, its existence was brought to the attention of the Board of Directors of the Baptist General Convention of Oklahoma. This led to a 54-2 vote by the Board of Directors at the Baptist Medical Center to close the program. Physicians who passionately advocated to continue this practice issued a joint statement saying, "If Jesus Christ were alive today, undoubtedly he would render help and comfort to the transsexual" [37].

It is thought that publicity around the Meyer paper [39] from Johns Hopkins played a role in an escalation of closure of other clinics [37]. Despite these closures, academic interest in the field led to the foundation of the Harry Benjamin Gender Dysphoria Association in 1979 [40]. This association had the goal of organizing professionals who were interested in the "study and care of transsexualism and gender dysphoria." It has since been renamed the World Professional Association for Transgender Health (WPATH) and has evolved into a large international multidisciplinary organization that provides Standards of Care for the treatment of transgender/gender-diverse (TGD) adolescents and adults [41].

In 1980, "transsexualism" and "gender identity disorder of childhood" were both recognized as illnesses in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders [42]. In 2013, the term "gender identity disorder" was replaced by "gender dysphoria in children" and "gender dysphoria in adolescents and adults" to diagnose and treat those transgender individuals who felt distress at the mismatch between their gender identities and their bodies, with the American Psychiatric Association stating that "it is important to note that gender nonconformity is not in itself a mental disorder" [43].

In 2019, the World Health Organization International Classification of Diseases version 11 replaced International Classification of Diseases-10's "transsexualism" and "gender identity disorder of children" with "gender incongruence of adolescence and adulthood" and "gender incongruence of childhood," respectively [44]. Gender incongruence was moved out of the "Mental and behavioral disorders" chapter into a new chapter, entitled "Conditions related to sexual health" [44]. This reflects current perspective that TGD identities are not mental health illnesses and that classifying them as such can cause significant stigma.

History of Gender-Affirming Medical Treatment in Adolescents

Providers in the Netherlands recognized the importance of preventing progression of a gender incongruent puberty by using a gonadotropin hormone-releasing hormone analog (GnRHa) followed by treatment with either testosterone or estrogen to bring physical characteristics into alignment with a patient's gender identity [45, 46]. This approach was first published by Drs. Cohen-Kettenis and van Goozen in 1998 in a case report of an adolescent treated with GnRHa by **Dr. Henriette A. Delemarre-van de Waal** (though not named in the publication) (Dr. **Sabine E. Hannema**, personal communication) [47]. Under the direction of Dr. Peggy Cohen-Kettenis, the first program geared to treating adolescents with gender dysphoria was established in the Netherlands [45]. Initially based on the guidelines of adult transgender treatment established by the Harry Benjamin Society and adapted to adolescents, patients first underwent comprehensive psychological assessment to establish a diagnosis of gender dysphoria (then called "gender identity disorder") and then initiated treatment with GnRH agonists (Gn-

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RHa) typically at Tanner 2–3 to pause pubertal development [45, 46]. The time spent under pubertal suppression would be used to further explore gender identity prior to committing to either estrogen or testosterone and their physical effects. This intervention with a GnRHa would also be somewhat of a diagnostic aid in that if it eased the distress; it was reasonable to correlate the distress with gender dysphoria as a primary cause. This was followed by hormone therapy around age of 16 years and then gender-affirming genital surgery at 18 years or later [45, 46, 48]. The "Dutch Protocol" [49] was adapted by practitioners internationally, though it was not until pediatric endocrinologist and adolescent medicine pediatrician **Dr. Norman Spack**, having traveled to Amsterdam to observe the clinic there, established the first formal US program geared specifically to transgender adolescents at Boston Children's Hospital: the Gender Management (subsequently replaced with Multispecialty) Service program in 2007 [50]. It should be noted that adolescents there and elsewhere across the USA had been treated outside of a structured program [50]. Clinical protocols at Gender Management Service were derived from direct observation, adaptation of the Dutch program, and a May 2005 consensus meeting (the Gender Identity Research and Education Society) and expanded upon previous guidelines from the Standards of Care of the WPATH and those from the Royal College of Psychiatrists [46, 51, 52].

The Endocrine Society guidelines, with input from the Pediatric Endocrine Society, the European Society for Paediatric Endocrinology, the European Society for Endocrinology, and WPATH, were first published in 2009 and recommended the use of GnRHa as a treatment for selected adolescents [53]. Pubertal suppression could be initiated when the individual reached Tanner 2 or 3, followed by gender-affirming hormones at age of 16 years. Subsequent standards of care and clinical practice guidelines published by WPATH (SOC 8 in 2022) [41], the University of California San Francisco in 2016 [54], and the Endocrine Society (updated in 2017) [55] continued to recommend treatment for adolescents starting with pubertal suppression at Tanner 2 and 3, with consideration of gender-affirming sex hormones in some adolescents younger than 16 years old (on a case-by-case basis) who had demonstrated strong and persistent gender dysphoria. Of note, the WPATH SOC 8 does not list minimum age requirements for gender-affirming medical care [41].

In 2014, a published resource guide providing contact information showed that there were 32 US and 2 Canadian programs available to treat TGD adolescents [56]. As of March 2022, there were about 60 recognized pediatric/adolescent multidisciplinary gender programs in the USA, though smaller programs and individual offices probably also provide care [57]. Some programs have been closed for political reasons with potentially dire consequences for both patients and practitioners [58].

Changing Prevalence of Trans Identities and the Rise of Nonbinary Identification

Worldwide, the prevalence of people declaring a gender identity that is different from that assigned at birth has risen sharply as the recognition of gender diversity, and its social acceptance has increased. Early estimates of prevalence for those seeking hormonal treatment are notable for relatively low prevalence and a heavy predominance of birth-assigned males. In 1968, two authors published estimates demonstrating this trend. In the USA, Pauly cited 1:100,000 birth-assigned males and 1:400,000 birth-assigned females [59]. In Sweden, the estimate again favored the birth-assigned males at 1:37,000 and birth-assigned females at 1:103,000 [60]. By the mid-80s, numbers had risen with a similar ratio of birth-assigned males at 1:18,000 and birth-assigned females at 1:54,000 [61]. The same year, authors in Singapore reported much higher numbers of 1:2,900 and 1:8,300 birth-assigned males and females, respectively [62]. The Williams Institute of the University of California Los Angeles School of Law has tracked prevalence of transgender identification in the USA. A report from 2022 (based on data from 2017, 2019, and 2020) revealed that the prevalence of adults in the USA who identified as transgender has remained stable at around 0.5% of the population, or 1.3 million adults. However, the percentage of trans-identified youth (ages 13–17) had notably increased in recent years from 0.7% to 1.4% of the population [63]. Recent reports have also noted a rise in nonbinary gender identification and a reversal in the sex ratio of adolescents presenting for gender-affirming care from a predominance of those designated male at birth to a predominance of individuals designated female at birth. In 2017, a large adolescent multidisciplinary survey noted that 63% of the presenting patients were birth-assigned females [64].

Legislative and Social Dynamics

Since 2016, many US states and European countries have introduced laws that restrict transgender youth from accessing gender-affirming care, team sports, and

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restrooms that are consistent with their gender identity [65]. Simultaneously, numerous reputable national and international academic medical societies have openly and repeatedly stated their opposition to these laws. This includes the Pediatric Endocrine Society [66, 67], the Endocrine Society [68, 69], the American Academy of Pediatrics [70], the American Medical Association [71], the United States Professional Association for Transgender Health [72], the American Association for Child and Adolescent Psychiatry [73], and in a united statement, also the American Psychiatric Association, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the American Osteopathic Association [74].These societies have stated that these bills are discriminatory and cause harm to the mental health of transgender youth. Despite this, some bills have passed successfully [65].

Conclusions

While there is a long-standing history acknowledging the existence of human gender diversity, the history of gender-affirming medical care for adolescents, in particular, is relatively brief. Evolving protocols for gender-diverse adolescents, first pioneered in the Netherlands, have been incorporated into clinical practice guidelines and standards of care published by the Endocrine Society and WPATH, respectively, and have been endorsed by major medical and mental health professional societies around the world. Notably, however, while there has been increased acceptance of gender diversity in some parts of the world, transgender adolescents and those who provide them with gender-affirming medical care, particularly in the USA, have been caught in the crosshairs of a culture war, with the risk of preventing access to care that published studies have indicated may be lifesaving. Despite such challenges and barriers to care, currently available evidence supports the benefits of an interdisciplinary model of gender-affirming medical care for transgender adolescents. Further long-term safety and efficacy studies are needed to optimize such care.

Statement of Ethics

Not applicable as this is a historical report and not a report of research.

Conflict of Interest Statement

Jeremi M. Carswell, Ximena Lopez, and Stephen M. Rosenthal declare no conflicts of interest.

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The Evolution of Adolescent Gender-Affirming Care: An Historical Perspective

Jeremi M. Carswell[a] Ximena Lopez[b] Stephen M. Rosenthal[c]

[a]Endocrinology Division, Department of Pediatrics, Boston Children's Hospital, Boston, MA, USA; [b]Division of Pediatric Endocrinology, Department of Pediatrics, Southwestern Medical Center, University of Texas, Dallas, TX, USA; [c]Division of Pediatric Endocrinology, Department of Pediatrics, Benioff Children's Hospital, University of California San Francisco, San Francisco, CA, USA

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Abstract
While individuals have demonstrated gender diversity throughout history, the use of medication and/or surgery to bring a person's physical sex characteristics into alignment with their gender identity is relatively recent, with origins in the first half of the 20th century. Adolescent gender-affirming care, however, did not emerge until the late 20th century and has been built upon pioneering work from the Netherlands, first published in 1998. Since that time, evolving protocols for gender-diverse adolescents have been incorporated into clinical practice guidelines and standards of care published by the Endocrine Society and World Professional Association for Transgender Health, respectively, and have been endorsed by major medical and mental health professional societies around the world. In addition, in recent decades, evidence has continued to emerge supporting the concept that gender identity is not simply a psychosocial construct but likely reflects a complex interplay of biological, environmental, and cultural factors. Notably, however, while there has been increased acceptance of gender diversity in some parts of the world, transgender adolescents and those who provide them with gender-affirming medical care, particularly in the USA, have been caught in the crosshairs of a culture war, with the risk of preventing access to care that published studies have indicated may be lifesaving. Despite such challenges and barriers to care, currently available evidence supports the benefits of an interdisciplinary model of gender-affirming medical care for transgender/gender-diverse adolescents. Further long-term safety and efficacy studies are needed to optimize such care.

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Introduction

The relatively recent recognition of diversity of "gender identity" – one's inner sense of self as male or female or somewhere on the gender spectrum – in the current culture belies its long-standing presence in cultures diverse and ancient. "Transgender" (sometimes referred to as "gender incongruence") is defined as a marked and persistent incongruence between an individual's experienced gender and their sex designated at birth. Transgender is often used as an umbrella term to encompass all gender identities that are not the same as the birth-assigned gender (typically based on the sex designated at

Karger@karger.com
www.karger.com/hrp

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Correspondence to:
Stephen M. Rosenthal, stephen.rosenthal@ucsf.edu

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birth) but may also be used specifically for a binary gender identification.

As our understanding of gender has been evolving over time, so has the language used to describe gender. Throughout this manuscript, the authors have primarily used the terminology of the present day, though historical descriptions will contain language that is clearly outdated. We have chosen to use these terms only to maintain the historical perspective in this context.

The Historic and Cultural Diversity of Gender

Though it may seem that transgender as a concept is a recent phenomenon, there are both ancient and diverse examples that underscore the understanding that humans have experienced gender as beyond the set of cultural norms assigned to them based on their genitals. In Greek and Roman mythology, there are legends of deities who defy traditional concepts of gender; the most famous may be Hermaphroditus, a son born of Hermes and Aphrodite. When the nymph Salmacis fell in love with him, their forms became merged, with the god depicted as having male genitalia with breasts and a more feminine body shape [1, 2]. Norse mythology gives us the notorious shape and sex shifting Loki, who was known for his trickery, appearing at times in a female form when it suited his purpose [1]. Several Indigenous North American tribes have long-standing recognition and language for gender and/or sexual minority-identified individuals that often signified a third gender, or a combination of male and female. Though the designation and roles varied among tribes, the term "two-spirit" was coined in 1990 during the international LGBT Native American Gathering and attributed to Elder Maya Laramee [3, 4]. This term is not specific to any one tribe or any one group of individuals but encompasses any indigenous member with gender-diverse identification or same-sex attraction.

Biological Underpinnings of Gender Identity

John Money, a New Zealand psychologist and faculty member in pediatrics at Johns Hopkins University beginning in the early 1950s, and co-founder of the Gender Identity Clinic at that university, promoted the concept that gender identity was influenced by "social learning and memory" in conjunction with biological factors [5]. However, a widely publicized case described in a book by John Colapinto published in 2000 lends strong support to the concept that gender identity is not primarily learned [6]. This book focused on a failed circumcision in an 8-month-old male resulting in loss of the penis, leading Money to advise the family to castrate the infant and raise him as a girl [6]. The child never accepted a female gender identity, became severely depressed, and changed gender to male during adolescence. He later committed suicide [6]. In subsequent years, evidence in support of biological underpinnings to gender identity development has continued to emerge, derived primarily from three biomedical disciplines: genetics, endocrinology, and neurobiology [7].

Starting in the late 1970s, heritability of being transgender was suggested from studies describing concordance of gender identity in monozygotic twin pairs and in father-son and brother-sister pairs [8, 9]. In the largest twin study evaluating gender identity, in which at least one member of a twin pair was transgender, there was a much greater likelihood that the other member of the twin pair was also transgender if they were identical versus nonidentical (but same sex) twins [10]. Attempts to identify polymorphisms in candidate genes that might be more prevalent in transgender versus cisgender individuals have been inconsistent. In particular, a 2009 study from Japan did not find any significant associations of transsexualism with polymorphisms in five candidate genes (encoding the androgen receptor, CYP19, ER-alpha, ER-beta, and the progesterone receptor) [11]. However, a 2019 study in 380 transgender women and 344 cisgender male controls demonstrated an over-representation of several allele combinations involving the androgen receptor in transgender women [12]. A subsequent study using whole-exome sequencing in a relatively small number of transgender males (n = 13) and transgender females (n = 17) demonstrated 21 variants in 19 genes that were associated with previously described estrogen receptor-activated pathways of sexually dimorphic brain development [13]. An association between polymorphisms in the estrogen receptor alpha gene promoter and a transgender male identity has also been reported [14].

The vast majority of transgender individuals do not have an intersex condition or any associated abnormality in sex steroid production or responsiveness [7]. However, studies in a variety of intersex conditions have informed our understanding of the potential role of hormones, particularly prenatal and early postnatal androgens, in gender identity development [7]. For example, several studies of 46,XX individuals with virilizing congenital adrenal hyperplasia caused by 21-hydroxylase deficiency demonstrated a greater prevalence of a transgender identity out-

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come (female to male) compared to the general population [15–17]. One such study published in 2006 demonstrated a relationship between severity of congenital adrenal hyperplasia and gender identity outcome, where 7% of patients with the severe salt-wasting form had gender dysphoria or a male gender identity, while no gender dysphoria was seen in any of the less severely affected individuals [16]. Studies in a variety of other hormonal and nonhormonal intersex conditions support a role of prenatal and/or postnatal androgens in gender identity development [7]. However, in 2011, a case report in a 46,XY individual with complete androgen insensitivity and a male gender identity challenged the concept that androgen receptor signaling is required for male gender identity development [18].

Neuroimaging studies that aim to understand the neurobiology of gender identity indicate that some sexually dimorphic brain structures are more closely aligned with gender identity than with physical sex characteristics in transgender adults prior to treatment with gender-affirming hormones [19–21]. A similar trend was reported in studies of gray matter in youth with gender dysphoria [22]. In 2021, an MRI study in transgender adults, also prior to treatment with gender-affirming sex hormones, found that transgender people have a unique brain phenotype "rather than being merely shifted towards either end of the male-female spectrum" [23]. Notably, in both transgender adolescents and adults, several functional brain studies looking at responses to odorous compounds or mental rotation tasks demonstrated that patterns typically observed to be sexually dimorphic were more closely aligned with gender identity than with physical sex characteristics, even before treatment with gender-affirming sex hormones [24–26].

History of Modern Gender-Affirming Medical Treatment

Though individuals have demonstrated gender diversity throughout history, the use of medication and/or surgery is relatively recent with origins in Germany in the first half of the 20th century and is credited to the pioneering work of Magnus Hirschfeld. The institution he founded, "Institut für Sexualwissenschaft (the Institute for Sexual Science)" in Berlin (1922), paved the way for the use of hormones and surgery [27]. In Hirschfeld's study of what he named "sexual intermediaries," he recognized that people may be born with a nature contrary to their assigned gender. In cases where the desire to live as the opposite sex was strong, he thought science ought to provide a means of transition. Innovative for his time, he argued that a person may be born with characteristics that did not fit into heterosexual or binary categories and supported the idea that a "third sex" existed naturally [27]. The first documented case of genital surgery was performed at the institute on Dorchen Richter in 1922 with orchiectomy and then 1931 with penectomy and vaginoplasty [27, 28]. Notable patients, including Lili Elbe (born Einar Wegener), the patient on whom the movie "The Danish Girl" is based, underwent a series of operations including transplant of both ovaries and a uterus [29].

This clinic would be a century old if it had not fallen victim to Nazi ideology and Hitler's mission to rid Germany of Lebensunwertes Leben, or "lives unworthy of living." What began as a sterilization program ultimately led to the extermination of millions of Jews, Gypsies, Soviet, and Polish citizens, as well as homosexuals and transgender people. When the Nazis came for the institute in 1933, Hirschfeld had fled to France. Troops swarmed the building and created a bonfire that engulfed more than 20,000 of his books, some of them rare copies that had helped provide a history for transgender people [27].

In the 1950s, German-American physician Harry Benjamin (1885–1986) introduced the term "transsexuality," defining a "transsexual" person as someone who identifies in opposition to their "biological sex" [30]. Harry Benjamin graduated cum laude from medical school in Tübingen, Germany, in 1912. He moved to New York City in 1914 to study tuberculosis, but over time, he became known as a geriatrician, endocrinologist, and sexologist [31]. He did not treat his first transgender patient until he was in his 60s, and his colleagues described him as follows: "Being a true physician, Benjamin treated all these patients as people and by respectfully listening to each individual voice, he learned from them what gender dysphoria was about" [32]. Notably, he did not describe "transsexualism" as a psychological problem, but as a biological condition that could be treated with hormone or surgical therapy [31]. He treated over 1,500 patients, and in 1966, he published the first medical textbook in this field, "The Transsexual Phenomenon" [33]. His work was very influential, and he became known as "The Father of Transsexualism" [31, 32].

Following World War II, gender-affirming treatment in the USA was limited to wealthy patients who could afford to travel to Europe, though they did so at great risk given the laws in several states outlawing "cross-dressing" [34]. Christine Jorgensen (1926–1989) brought visibility

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to transgender patients, having undergone medical and surgical transition in Europe after she had served time in the US military as a male [35].

Influenced by Dr. Benjamin Harris' "The Transsexual Phenomenon" [33], Johns Hopkins Hospital in Baltimore became the first academic institution in the USA to offer gender-affirming surgery [36]. Soon after, at least another 8 academic institutions opened transgender programs throughout the 1960–1970s (University of Minnesota, University of Washington, Northwestern/Cook County Health in Chicago, Stanford University, Cleveland Clinic, University of Colorado, Baptist Medical Center in Oklahoma City, and Washington University in St. Louis) [37].

Toward the end of the 1970s, however, most transgender programs closed access to new patients. These closures were done quietly out of public view, and the causes were often not disclosed [37]. At Johns Hopkins Hospital, Paul McHugh became the Chair of Psychiatry in 1975. From the moment he was hired, McHugh openly stated he intended to stop gender-affirming surgery at this hospital [38]. Under his leadership, another Johns Hopkins psychiatrist, Dr. Jon Meyer, published a study of 50 patients which concluded that gender-affirming surgery did not provide "objective" benefit for transgender individuals [39]. This publication led to the sudden closure of the clinic in 1979 [36]. Interestingly, John Money, who believed that gender could be learned and who co-founded the Johns Hopkins gender clinic, publicly expressed opposition to Meyer's conclusions of his study [36].

The program at the Baptist Medical Center in Oklahoma City had been functioning since 1973. However, in 1977, its existence was brought to the attention of the Board of Directors of the Baptist General Convention of Oklahoma. This led to a 54-2 vote by the Board of Directors at the Baptist Medical Center to close the program. Physicians who passionately advocated to continue this practice issued a joint statement saying, "If Jesus Christ were alive today, undoubtedly he would render help and comfort to the transsexual" [37].

It is thought that publicity around the Meyer paper [39] from Johns Hopkins played a role in an escalation of closure of other clinics [37]. Despite these closures, academic interest in the field led to the foundation of the Harry Benjamin Gender Dysphoria Association in 1979 [40]. This association had the goal of organizing professionals who were interested in the "study and care of transsexualism and gender dysphoria." It has since been renamed the World Professional Association for Transgender Health (WPATH) and has evolved into a large international multidisciplinary organization that provides Standards of Care for the treatment of transgender/gender-diverse (TGD) adolescents and adults [41].

In 1980, "transsexualism" and "gender identity disorder of childhood" were both recognized as illnesses in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders [42]. In 2013, the term "gender identity disorder" was replaced by "gender dysphoria in children" and "gender dysphoria in adolescents and adults" to diagnose and treat those transgender individuals who felt distress at the mismatch between their gender identities and their bodies, with the American Psychiatric Association stating that "it is important to note that gender nonconformity is not in itself a mental disorder" [43].

In 2019, the World Health Organization International Classification of Diseases version 11 replaced International Classification of Diseases-10's "transsexualism" and "gender identity disorder of children" with "gender incongruence of adolescence and adulthood" and "gender incongruence of childhood," respectively [44]. Gender incongruence was moved out of the "Mental and behavioral disorders" chapter into a new chapter, entitled "Conditions related to sexual health" [44]. This reflects current perspective that TGD identities are not mental health illnesses and that classifying them as such can cause significant stigma.

History of Gender-Affirming Medical Treatment in Adolescents

Providers in the Netherlands recognized the importance of preventing progression of a gender incongruent puberty by using a gonadotropin hormone-releasing hormone analog (GnRHa) followed by treatment with either testosterone or estrogen to bring physical characteristics into alignment with a patient's gender identity [45, 46]. This approach was first published by Drs. Cohen-Kettenis and van Goozen in 1998 in a case report of an adolescent treated with GnRHa by **Dr. Henriette A. Delemarre-van de Waal** (though not named in the publication) (Dr. **Sabine E. Hannema**, personal communication) [47]. Under the direction of Dr. Peggy Cohen-Kettenis, the first program geared to treating adolescents with gender dysphoria was established in the Netherlands [45]. Initially based on the guidelines of adult transgender treatment established by the Harry Benjamin Society and adapted to adolescents, patients first underwent comprehensive psychological assessment to establish a diagnosis of gender dysphoria (then called "gender identity disorder") and then initiated treatment with GnRH agonists (Gn-

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RHa) typically at Tanner 2–3 to pause pubertal development [45, 46]. The time spent under pubertal suppression would be used to further explore gender identity prior to committing to either estrogen or testosterone and their physical effects. This intervention with a GnRHa would also be somewhat of a diagnostic aid in that if it eased the distress; it was reasonable to correlate the distress with gender dysphoria as a primary cause. This was followed by hormone therapy around age of 16 years and then gender-affirming genital surgery at 18 years or later [45, 46, 48]. The "Dutch Protocol" [49] was adapted by practitioners internationally, though it was not until pediatric endocrinologist and adolescent medicine pediatrician **Dr. Norman Spack**, having traveled to Amsterdam to observe the clinic there, established the first formal US program geared specifically to transgender adolescents at Boston Children's Hospital: the Gender Management (subsequently replaced with Multispecialty) Service program in 2007 [50]. It should be noted that adolescents there and elsewhere across the USA had been treated outside of a structured program [50]. Clinical protocols at Gender Management Service were derived from direct observation, adaptation of the Dutch program, and a May 2005 consensus meeting (the Gender Identity Research and Education Society) and expanded upon previous guidelines from the Standards of Care of the WPATH and those from the Royal College of Psychiatrists [46, 51, 52].

The Endocrine Society guidelines, with input from the Pediatric Endocrine Society, the European Society for Paediatric Endocrinology, the European Society for Endocrinology, and WPATH, were first published in 2009 and recommended the use of GnRHa as a treatment for selected adolescents [53]. Pubertal suppression could be initiated when the individual reached Tanner 2 or 3, followed by gender-affirming hormones at age of 16 years. Subsequent standards of care and clinical practice guidelines published by WPATH (SOC 8 in 2022) [41], the University of California San Francisco in 2016 [54], and the Endocrine Society (updated in 2017) [55] continued to recommend treatment for adolescents starting with pubertal suppression at Tanner 2 and 3, with consideration of gender-affirming sex hormones in some adolescents younger than 16 years old (on a case-by-case basis) who had demonstrated strong and persistent gender dysphoria. Of note, the WPATH SOC 8 does not list minimum age requirements for gender-affirming medical care [41].

In 2014, a published resource guide providing contact information showed that there were 32 US and 2 Canadian programs available to treat TGD adolescents [56]. As of March 2022, there were about 60 recognized pediatric/adolescent multidisciplinary gender programs in the USA, though smaller programs and individual offices probably also provide care [57]. Some programs have been closed for political reasons with potentially dire consequences for both patients and practitioners [58].

Changing Prevalence of Trans Identities and the Rise of Nonbinary Identification

Worldwide, the prevalence of people declaring a gender identity that is different from that assigned at birth has risen sharply as the recognition of gender diversity, and its social acceptance has increased. Early estimates of prevalence for those seeking hormonal treatment are notable for relatively low prevalence and a heavy predominance of birth-assigned males. In 1968, two authors published estimates demonstrating this trend. In the USA, Pauly cited 1:100,000 birth-assigned males and 1:400,000 birth-assigned females [59]. In Sweden, the estimate again favored the birth-assigned males at 1:37,000 and birth-assigned females at 1:103,000 [60]. By the mid-80s, numbers had risen with a similar ratio of birth-assigned males at 1:18,000 and birth-assigned females at 1:54,000 [61]. The same year, authors in Singapore reported much higher numbers of 1:2,900 and 1:8,300 birth-assigned males and females, respectively [62]. The Williams Institute of the University of California Los Angeles School of Law has tracked prevalence of transgender identification in the USA. A report from 2022 (based on data from 2017, 2019, and 2020) revealed that the prevalence of adults in the USA who identified as transgender has remained stable at around 0.5% of the population, or 1.3 million adults. However, the percentage of trans-identified youth (ages 13–17) had notably increased in recent years from 0.7% to 1.4% of the population [63]. Recent reports have also noted a rise in nonbinary gender identification and a reversal in the sex ratio of adolescents presenting for gender-affirming care from a predominance of those designated male at birth to a predominance of individuals designated female at birth. In 2017, a large adolescent multidisciplinary survey noted that 63% of the presenting patients were birth-assigned females [64].

Legislative and Social Dynamics

Since 2016, many US states and European countries have introduced laws that restrict transgender youth from accessing gender-affirming care, team sports, and

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restrooms that are consistent with their gender identity [65]. Simultaneously, numerous reputable national and international academic medical societies have openly and repeatedly stated their opposition to these laws. This includes the Pediatric Endocrine Society [66, 67], the Endocrine Society [68, 69], the American Academy of Pediatrics [70], the American Medical Association [71], the United States Professional Association for Transgender Health [72], the American Association for Child and Adolescent Psychiatry [73], and in a united statement, also the American Psychiatric Association, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the American Osteopathic Association [74].These societies have stated that these bills are discriminatory and cause harm to the mental health of transgender youth. Despite this, some bills have passed successfully [65].

Conclusions

While there is a long-standing history acknowledging the existence of human gender diversity, the history of gender-affirming medical care for adolescents, in particular, is relatively brief. Evolving protocols for gender-diverse adolescents, first pioneered in the Netherlands, have been incorporated into clinical practice guidelines and standards of care published by the Endocrine Society and WPATH, respectively, and have been endorsed by major medical and mental health professional societies around the world. Notably, however, while there has been increased acceptance of gender diversity in some parts of the world, transgender adolescents and those who provide them with gender-affirming medical care, particularly in the USA, have been caught in the crosshairs of a culture war, with the risk of preventing access to care that published studies have indicated may be lifesaving. Despite such challenges and barriers to care, currently available evidence supports the benefits of an interdisciplinary model of gender-affirming medical care for transgender adolescents. Further long-term safety and efficacy studies are needed to optimize such care.

Statement of Ethics

Not applicable as this is a historical report and not a report of research.

Conflict of Interest Statement

Jeremi M. Carswell, Ximena Lopez, and Stephen M. Rosenthal declare no conflicts of interest.

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There were no data generated for this report.

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From: [redacted]@ucsf.edu>
Sent: Wednesday, November 30, 2022 12:09 PM PST
To: [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi team,

Since our schedules all have a tendency to fill up, I'll go ahead and send a meeting invite to you all for 12/16 at 3pm.

Please accept the meeting if you're able to make it! Thank you!

[redacted], LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: [redacted] [redacted] <[redacted].[redacted]@ucsf.edu>
Sent: Tuesday, November 29, 2022 10:57 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

I would be available 3 pm to 5:30 pm on 12/16.

[redacted] [redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted].[redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 29, 2022 10:16 AM
To: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted],

Yes, Friday afternoon, 12/16, at 1 PM or later, works for me. Let's see what works for the others.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

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Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 29, 2022 10:13 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi Steve,

That's a great question, and one that I'm not sure I have an answer to... I'm hopeful that as [redacted] has time to get settled into this role (and [redacted], too), it'll become more clear what capacity SW will have with the total FTE of 1.5. So perhaps it's a wait and see?

In the meantime, I would love to opportunity to come up with a plan for [redacted]s workflow until her counterpart is hired.

Given your time away, should we aim for the afternoon of 12/16?

Let me know - thank you!
[redacted]

[redacted] LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 29, 2022 9:22 AM
To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted]

I think that you've made a clear and compelling argument for why having one social worker for the CAGC at 36 hours/week just doesn't cut it. It's my understanding that hiring a replacement for [redacted]) at 0.6 FTE (24 hours/week) is in process. Do you think that additional FTE will enable the ability for SW to carry out the tasks that have been so valued in our interdisciplinary model of care?

I'm happy to participate in a meeting to further discuss CAGC SW. I have most flexibility on Friday afternoons, but will be away 12/1-12/11.

Thanks very much,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center

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University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Monday, November 28, 2022 11:18 PM
To: [redacted], [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi everyone,

My apologies for the delay in my reply... and thank you for your thoughtful responses!

We hear you loud and clear - having SW do an initial assessment seems very important! We trust you know what your patients & families need.

However, the feedback we have been hearing from [redacted] for a long time is that their job responsibilities had become unsustainable. Doing all the pre-clinic assessments, helping families get connected with qualified community mental health professionals, and providing general and crisis support to established families had become too heavy of a workload (and this was with the help of 2 MSW students and some time from [redacted] (.2 FTE)).

We would like to re-define the essential tasks of SW in the CAGC, to ensure that we are expecting a reasonable amount of work out of [redacted] during her 36 hour work-week.

Can we find a time to meet in the next week and discuss the role of SW in CAGC going forward?

I assume you all are busier than I am, so please let me know when it's a good time to meet. Generally, I'm available most times except for Mondays and Thursday mornings.

A million thanks! And we are really looking forward to talking this through with you all.

[redacted]

[redacted]LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
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From: [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, November 23, 2022 12:32 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks, [redacted] for putting so much thought into this. I feel strongly that the social worker, not the scheduler, takes full responsibility for any pre-clinic contact with the family aside from the scheduling. The pre-clinic questionnaire and social

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work contact is actually the beginning of the gender care prior to the first visit and requires someone trained to take on this role. To date, the social work team has been invaluable in this regard.

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: [redacted]ucsf.edu>
Sent: Wednesday, November 23, 2022 11:00 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Good morning everyone,

[redacted] and I had a productive meeting with [redacted] last week about how to use this transitional time to better streamline patients' entry into the CAGC clinic.

Our understanding of the current state is: [redacted] contacts all patients with new patient appointments in the upcoming month, and completes the following questionnaire over the phone. This information is then put into the chart for providers to have at the ready for the patient's first visit. Copy of the assessment is here:
CAGC First Visit Questionnaire (1).docx

Our proposal for changes to make: [redacted] will conduct a simplified version of the questionnaire with families over the phone when she calls to schedule them. A week before their appointment, she will do a reminder call & offer to have a Social Worker ([redacted]) contact them for any additional support needs. Additionally, if [redacted] identifies any potential complicating psychosocial factors during her phone conversations with families (ie unclear custody arrangement, patient with significant mental health concerns, transportation/insurance access issues, etc), [redacted] will send a referral to [redacted] via the Apex referral system for follow-up.

Curious to know a few things...

1. What are your initial thoughts/responses/concerns to this proposed change of workflow?
2. Is a SWer required to make contact with every patient, or is it permissible for it to be as-indicated?
3. Can this questionnaire be simplified at all?

Happy to sit and have a meeting about this if you'd prefer! Thanks again for your partnership.

[redacted] & [redacted]

[redacted]LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 4:23 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted]

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The DPH grant is ending as of 11/30/22, so all CAGC Social Work support going forward will be from the Medical Center. I'm hoping you and [redacted] can soon resolve the total Social Work FTE.

Please keep me posted on the search for the new CAGC Social Worker position.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 4:00 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: RE: CAGC SW

Hello,

I was also under the impression that we had 2x 0.9 positions, but recently heard differently and was told we have 1.6 total for CACG. I will continue to explore this further.
If we actually do have only 1.6, do we still have access to the .3 FTE from the DPH grant?

Also, we have hired for the 2nd position, [redacted] is set to start on 11/7. We will send out a bio to the team soon.
I submitted an eRF to replace [redacted] and am waiting for this to be approved and posted.

Thank you,

[redacted] **LCSW**
Pediatric Social Work Manager
UCSF Benioff Children's Hospital, San Francisco

Pediatric Social Work Department
1975 4th Street, Box 4012 | San Francisco, CA 94158
Office: 415.514-7668
Email: [redacted]@ucsf.edu
Pronouns: she, hers, her, ella

UCSF Benioff Children's Hospitals

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 3:21 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi All,

Obtained via CPRA by Judicial Watch, Inc.

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I have cc'd [redacted]. We (the CAGC) have had a 0.9 FTE Social Worker paid for by the Medical Center, and, as on 2/17/22 (see email from [redacted], below), we were awarded an additional 0.9 FTE Social Worker based on the needs of the CAGC. Therefore, we should have two Social Workers, each at 0.9 FTE for the CAGC ASAP --The funding for the 2nd Social Worker was approved 8 months ago!

I understand that we have a replacement for the position currently held by [redacted], who will be leaving UCSF as of 11/11/22.

Please let me know if the position for the 2nd Social Worker has been posted, and if not yet posted, please let me know when this is likely to happen. Again, the funding for the 2nd Social Worker was approved 8 months ago, so we really need to move forward with the hiring process.

Thank you,

Steve

From: [redacted]@ucsf.edu>
Sent: Thursday, February 17, 2022 4:42 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu> [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC FTE Requests

All,

I have great news!

We received final approval on the 4.9 FTE investment request for CAGC. The positions are currently being posted by HR. Here's what was approved:

- 1.0 FTE Psychologist
- 1.0 FTE Practice Coordinator
- 0.9 FTE Social Worker
- 1.0 FTE LVN
- 1.0 FTE RN

I want to thank all of you for your patience as we worked to get this to the finish line. I also want to give kudos to Jo for her leadership in getting the request organized and building a compelling business case!

Thanks,

[redacted]

[redacted] MBA
Director
Children's Ambulatory Services
UCSF Health

Office: (415) 514-6388
Mobile: [redacted]

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 3:02 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: CAGC SW

Hi,

Please contact Steve and [redacted] regarding that information.

Thank you,

Dr. [redacted], DNP, AC-PNP-BC
Nurse Practitioner
UCSF Pediatric Endocrinology

From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:18 AM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks [redacted].

Any info on where the funding from the other .9 FTE is from, if it's not also Medical Center?

Thanks,
[redacted]

[redacted] LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:17 AM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC SW

Here is the response on SW FTE:

2 x 0.9 FTE and one of those 0.9 FTE is from med center

[redacted] PNP
UCSF Pediatric Endocrinology
Assistant Clinical Professor
Department of Family Health Care
UCSF School of Nursing

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 30, 2022 4:28 PM PST
To: [redacted]
Subject: Re: Match Results!

Wonderful news! Congrats!

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]
Sent: Wednesday, November 30, 2022 4:14 PM
To: [redacted]
Subject: Re: Match Results!

Great news! Congrats!

[redacted] MD
Assistant Clinical Professor of Pediatrics
Division of Pediatric Endocrinology and Diabetes

UCSF Benioff Children's Hospital Oakland
747 52nd Street | Oakland, CA 94609
tel: 510-428-3654| fax: 510-450-5614

Obtained via CPRA by Judicial Watch, Inc.

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[redacted]@ucsf.edu

UCSF Benioff Children's Hospitals

From: [redacted]@ucsf.edu>
Sent: Wednesday, November 30, 2022 4:09 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; C[redacted]@ucsf.edu>; L[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@bsd.uchicago.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf

Obtained via CPRA by Judicial Watch, Inc.

Subject: Match Results!

Sent on behalf of [redacted] MD

Hi everyone,

I just wanted to let you know that we successfully filled our two fellowship slots for next year! I'm thrilled to announce that [redacted] from Children's Oakland and [redacted] from the Boston combined residency program will be joining us next year. I want to thank all of you who met with the applicants for your time and patience during the process.

Best,
[redacted]

[redacted] M.D.
Associate Clinical Professor of Pediatrics, Division of Endocrinology
Program Director, Pediatric Endocrinology Fellowship Training Program
UCSF Diabetes Center
UCSF School of Medicine
Director of Clinical and Translational Medicine
Immune Tolerance Network
www.ucsf.edu
www.immunetolerance.org

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Stephen M. Rosenthal

Stephen M. Rosenthal, MD, Professor of Pediatrics at University of California San Francisco (UCSF), has served as Program Director for Pediatric Endocrinology and Director of the Pediatric Endocrine Clinics, and currently serves as co-founder and Medical Director of the multidisciplinary UCSF Child and Adolescent Gender Center (CAGC). He is Principal Investigator (PI) (multiple PI format) for NIH/NICHD "The Impact of Early Medical Treatment in Transgender Youth" and co-Investigator on two additional NIH-funded studies focused on optimizing care of transgender/gender diverse youth. He has also co-directed a collaboration between the UCSF CAGC and the San Francisco Department of Public Health to develop community outreach services for gender diverse youth. Dr. Rosenthal has recently completed his terms as President of the Pediatric Endocrine Society and as Vice President and member of the Board of Directors of the Endocrine Society. He is currently a member of the Board of Directors of the World Professional Association for Transgender Health.

Dr. Rosenthal's principal non-work passion is figure skating. He has participated in various adult national and international competitions, most recently in Paris, August, 2018.

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 30, 2022 5:41 PM PST
To: [redacted]@scdi.org.vn>; [redacted] <[redacted]@ucsf.edu>; [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

Hi [redacted]

How about January 9 from 7:00-9:00 PM? It looks like this might work for [redacted]. It would be wonderful if this also works for [redacted]

Thanks and best wishes,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@scdi.org.vn>
Sent: Sunday, November 27, 2022 7:41 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

This Message Is From an Untrusted Sender
You have not previously corresponded with this sender.

Dear Dr. Stephen, Dr. [redacted] and Dr. [redacted],
Thank you very much for your kind support. Because of the visa submission requirement so all the team members have booked their round-trip flight (from Hanoi to LA and back) before I received your email. And I also understand that the pandemic situation is still serious in U.S. Therefore, could I suggest we have a zoom meeting in about 2 hours with Vietnam team member during their time in LA? if it is appropriate, I will share with you our detail agenda for this trip so we can arrange this meeting.

Thank you and warm regards,

[redacted]

[redacted] (Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
SCDI | Số 9 ngách 30 ngõ 165 Thái Hà, P.Láng Hạ, Q.Đống Đa | Hanoi | Vietnam
T +84 (0)24 3572 0679 (số máy lẻ: 161) | F +84 (0)4 3572 0689 | M [redacted]
www.scdi.org.vn | www.facebook.com/scdivietnam | https://www.youtube.com/SCDIVietnam
One ream (500 sheets) of paper is equivalent to 5% of a tree. Please consider the trees before printing this email.

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 28, 2022 3:31 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@scdi.org.vn>

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Cc: [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

I would love to be able to meet, but I'm on vacation and away January 1st through 8th. I will be back on the 9th, but that may be too late for a visit since [redacted], you all be completing your U.S. visit on January 11th.

Best,
[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 24, 2022 11:09 AM
To: [redacted]@scdi.org.vn>
Cc: [redacted] <[redacted]@ucsf.edu>; [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

Dear [redacted],

It's very nice to hear from you! I apologize for my delayed response—just a very busy time. I would be able to meet with you during the day on Tuesday, January 3rd, starting at 1 PM. Our full Child and Adolescent Gender Center team is not currently meeting in person because of the pandemic, but rather by telehealth. However, I have cc'd my colleague, Dr. [redacted], whom you met in Hanoi, who may also be available to meet on the afternoon of January 3rd. Please let me know if January 3rd at 1 PM works for you, and i can send you details of where we can meet. I have also cc'd Dr. [redacted], in the event that she is also able to meet at that time.

Best wishes,

Sincerely,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
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550 16th St., 4th Floor, #4635
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Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@scdi.org.vn>
Sent: Tuesday, November 15, 2022 6:30 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: SCDI - Visit trip for services providers and policy makers from Vietnam

This Message Is From an External Sender
This message came from outside your organization.

Dear Dr. Stephen,
I hope this email finds you well. I am writing to you to share that we are currently arranging a visit trip for a team of 5 people: 1 surgeon, 1 endocrinologist, 1 psychologist, 1 SCDI officer and 1 person on the drafting team to Los Angeles to visit Dr. [redacted] hospital, community people and policy makers there to learn about the cooperate between 3 services for transgender people. As you may know that we are advocating for the drafted law on gender affirmation and under the

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drafted law, the Ministry of Health need to develop 2 guidelines on surgery and psychological support but the drafting team don't have any ideas for this. They have learnt from other countries via documents we and our partners provided for them. We expect with this trip, they will have the opportunity to better understand this coordination as well as the support needed for transgender people. I know Los Angeles is a very good practice to learn but I wonder if we have time, may we visit you, your hospital and meeting with community organization, policy makers (if applicable) in San Francisco. The team will be in U.S from 2 - 11 January 2023 and we can have 3 days in San Francisco.
Thank you very much and I am looking forward to hearing from you.

Warm regards,

[redacted]

SCDI
Develop Together

[redacted] (Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
SCDI | Số 9 ngách 30 ngõ 165 Thái Hà, P.Láng Hạ, Q.Đống Đa | Hanoi | Vietnam
T +84 (0)24 3572 0679 (số máy lẻ: 161) | F +84 (0)4 3572 0689 | M [redacted]
www.scdi.org.vn | www.facebook.com/scdivietnam | https://www.youtube.com/SCDIVietnam
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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, November 30, 2022 5:44 PM PST
To: [redacted]@gmail.com>
CC: [redacted]@ucsf.edu>; [redacted]@sbcglobal.net>; [redacted]@csmc.edu>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

Hi [redacted]

Thanks for your nice note and offer to host a dinner! I just cc'd you on an email back to [redacted] who noted that they are unable to come to SF, but requested a 2-hour zoom meeting with you, [redacted] and me. Hopefully, that will work out!

I hope you and [redacted] are both doing well!

Love,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@gmail.com>
Sent: Thursday, November 24, 2022 12:27 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted]@gmail.com [redacted]@gmail.com>; [redacted]@ucsf.edu>; [redacted]@sbcglobal.net>; [redacted]@csmc.edu>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

This Message Is From an External Sender
This message came from outside your organization.

Happy Thanksgiving all!
I want to send this out while I'm thinking of it.
I have a pie in the oven as I write!

Should we have dinner at our home? I know [redacted] will want to see everyone, too! It would be nice if [redacted] could come up.. Anyone else?

At any rate- as I said, I want to send this out and get back to my kitchen/ [redacted] and I are having a quiet meal thi year as we are still contagious but feeling fine. India was just amazing and I hope we can arrange another "Vietnam" type expedition. TBD.
More later,

Love,

[redacted]

> On Nov 24, 2022, at 12:21 PM, [redacted]@gmail.com> wrote:
>
> Dear All-
>
> I somehow missed this email. I would be happy to meet then. Let me know as soon as you can regarding the time as it will involve rearranging my schedule, but that will not be a problem given advance notice. it will be wonderful to see you again. We can also arrange a time/place to socialize..
>
> Best,
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> >
> > Best wishes,
> >
> > Sincerely,
> >
> > Steve
> >
> > Stephen M. Rosenthal, M.D.
> > Professor of Pediatrics
> > Division of Pediatric Endocrinology
> > Medical Director, Child and Adolescent Gender Center
> > University of California, San Francisco
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> > Director, World Professional Association for Transgender Health
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> > Past President, Pediatric Endocrine Society
> >
> > Tel: (415) 476-2266
> > Fax: (415) 476-5356
> > email: Stephen.Rosenthal@ucsf.edu
> >
> > ---
> >
> > **From:** [redacted]@scdi.org.vn>
> > **Sent:** Tuesday, November 15, 2022 6:30 AM
> > **To:** Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
> > **Subject:** SCDI - Visit trip for services providers and policy makers from Vietnam
> >
> > **This Message Is From an External Sender**
> > This message came from outside your organization.
> >
> > Dear Dr. Stephen,
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for transgender people. As you may know that we are advocating for the drafted law on gender affirmation and under the drafted law, the Ministry of Health need to develop 2 guidelines on surgery and psychological support but the drafting team don't have any ideas for this. They have learnt from other countries via documents we and our partners provided for them. We expect with this trip, they will have the opportunity to better understand this coordination as well as the support needed for transgender people. I know Los Angeles is a very good practice to learn but I wonder if we have time, may we visit you, your hospital and meeting with community organization, policy makers (if applicable) in San Francisco. The team will be in U.S from 2 - 11 January 2023 and we can have 3 days in San Francisco.
Thank you very much and I am looking forward to hearing from you.

Warm regards,

[redacted]

<Outlook-1496240420.png>
[redacted] Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
SCDI | Số 8 ngách 30 ngõ 165 Thái Hà, P.Láng Hạ, Q.Đống Đa | Hanoi | Vietnam
T +84 (0)24 3572 0679 (số máy lẻ: 161) | F +84 (0)4 3572 0680 | M [redacted]
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From: [redacted]@cshs.org>
Sent: Wednesday, November 30, 2022 10:00 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@gmail.com>
CC: [redacted] <[redacted]@ucsf.edu>; [redacted]@sbcglobal.net>
Subject: Re: [External] Re: SCDI - Visit trip for services providers and policy makers from Vietnam

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Hi All –
I would love to come to SF for dinner, [redacted] to see you all.
I hope that things work out with the Vietnam group. The visa issue is a challenge – it takes so long to get. I hope that they are able to come.
Ill keep you posted.
I do think that a Zoom call would be fantastic, though, as an alternative.

[redacted] I hope that you are well and all is well with your grandchild.

Warm regards to you, [redacted] and Steve.

[redacted]

From: "Rosenthal, Stephen" <Stephen.Rosenthal@ucsf.edu>
Date: Wednesday, November 30, 2022 at 5:45 PM
To: [redacted]@gmail.com>
Cc: "[redacted]" <[redacted]@ucsf.edu>, [redacted]@sbcglobal.net>, [redacted]@cshs.org>
Subject: [External] Re: SCDI - Visit trip for services providers and policy makers from Vietnam

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Do not click on links or open attachments unless you know the content is safe. Protect your username and password.

Hi [redacted]

Thanks for your nice note and offer to host a dinner! I just cc'd you on an email back to [redacted] who noted that they are unable to come to SF, but requested a 2-hour zoom meeting with you, [redacted] and me. Hopefully, that will work out!

I hope you and [redacted] are both doing well!

Love,

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Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel: (415) 476-2286
Fax: (415) 476-5256
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@gmail.com>
Sent: Thursday, November 24, 2022 12:27 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted]@gmail.com [redacted]@gmail.com>; [redacted] <[redacted]@ucsf.edu>; [redacted]@sbcglobal.net>; [redacted]@csmc.edu>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

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More later.

Love,

[redacted]

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Best wishes,

Sincerely,

Steve

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Medical Director, Child and Adolescent Gender Center
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@scdi.org.vn>
Sent: Tuesday, November 15, 2022 6:30 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: SCDI - Visit trip for services providers and policy makers from Vietnam

---

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Dear Dr. Stephen,
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Thank you very much and I am looking forward to hearing from you.

Warm regards,

[redacted]

<Outlook-3496240420.png>
[redacted] Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
SCDI | Số 9 ngách 30 ngõ 165 Thái Hà, P Láng Hạ, Q Đống Đa | Hanoi | Vietnam
T +84 (0)24 3572 0679 (số máy lẻ: 161) | F +84 (0)4 3572 0688 | M [redacted]
www.scdi.org.vn | www.facebook.com/scdivietnam | https://www.youtube.com/SCDIvietnam
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IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is strictly prohibited. Thank you for your cooperation.

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From: [redacted]@ucsf.edu>
Sent: Thursday, December 01, 2022 8:57 AM PST
To: [redacted]@cshs.org>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@gmail.com>
CC: [redacted]@sbcglobal.net>
Subject: Re: [External] Re: SCDI - Visit trip for services providers and policy makers from Vietnam

We'd love to see you, too, [redacted] I'm available on January 9th and will just hold it open hoping for the Visas to come through.

Best,
[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: [redacted]@cshs.org>
Sent: Wednesday, November 30, 2022 10:00 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@gmail.com>
Cc: [redacted]@ucsf.edu>; [redacted]@sbcglobal.net>
Subject: Re: [External] Re: SCDI - Visit trip for services providers and policy makers from Vietnam

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Hi All –
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Ill keep you posted.
I do think that a Zoom call would be fantastic, though, as an alternative.

[redacted] I hope that you are well and all is well with your grandchild.

Warm regards to you, [redacted] and Steve.

[redacted]

From: "Rosenthal, Stephen" <Stephen.Rosenthal@ucsf.edu>
Date: Wednesday, November 30, 2022 at 5:45 PM
To: [redacted]@gmail.com>
Cc: [redacted]@ucsf.edu>, [redacted]@sbcglobal.net>, [redacted]@cshs.org>
Subject: [External] Re: SCDI - Visit trip for services providers and policy makers from Vietnam

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I hope you and [redacted] are both doing well!

Love,

Steve

Stephen M. Rosenthal, M.D.
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Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
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Sent: Thursday, November 24, 2022 12:27 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted]@gmail.com [redacted]@gmail.com>; [redacted]@ucsf.edu>; [redacted]@sbcglobal.net>; [redacted]@csmc.edu>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

This Message Is From an External Sender
This message came from outside your organization.

Happy Thanksgiving all!
I want to send this out while I'm thinking of it.
I have a pie in the oven as I write!

Should we have dinner at our home? I know [redacted] will want to see everyone, too! It would be nice if [redacted] could come up.. Anyone else?

At any rate- as I said, I want to send this out and get back to my kitchen/. [redacted] and I are having a quiet meal thi year as we are still contagious but feeling fine. India was just amazing and I hope we can arrange another "Vietnam" type expedition. TBD.
More later,

Love,

[redacted]

On Nov 24, 2022, at 12:21 PM, [redacted]@gmail.com> wrote:

Dear All-

I somehow missed this email. I would be happy to meet then. Let me know as soon as you can regarding the time as it will involve rearranging my schedule, but that will not be a problem given advance notice. it will be wonderful to see you again. We can also arrange a time/place to socialize.

Best,

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

[redacted]

On Nov 24, 2022, at 11:09 AM, Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu> wrote:

Dear [redacted],

It's very nice to hear from you! I apologize for my delayed response—just a very busy time. I would be able to meet with you during the day on Tuesday, January 3rd, starting at 1 PM. Our full Child and Adolescent Gender Center team is not currently meeting in person because of the pandemic, but rather by telehealth. However, I have cc'd my colleague, Dr. [redacted] whom you met in Hanoi, who may also be available to meet on the afternoon of January 3rd. Please let me know if January 3rd at 1 PM works for you, and I can send you details of where we can meet. I have also cc'd [redacted] in the event that she is also able to meet at that time.

Best wishes,

Sincerely,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel: (415) 476-2286
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@scdi.org.vn>
Sent: Tuesday, November 15, 2022 6:30 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: SCDI - Visit trip for services providers and policy makers from Vietnam

---

This Message Is From an External Sender
This message came from outside your organization.

Dear Dr. Stephen,
I hope this email finds you well. I am writing to you to share that we are currently arranging a visit trip for a team of 5 people: 1 surgeon, 1 endocrinologist, 1 psychologist, 1 SCDI officer and 1 person on the drafting team to Los Angeles to visit Dr. [redacted] hospital, community people and policy makers there to learn about the cooperate between 3 services for transgender people. As you may know that we are advocating for the drafted law on gender affirmation and under the drafted law, the Ministry of Health need to develop 2 guidelines on surgery and psychological support but the drafting team don't have any ideas for this. They have learnt from other countries via documents we and our partners provided for them. We expect with this trip, they will have the opportunity to better understand this coordination as well as the support needed for transgender people. I know Los Angeles is a very good practice to learn but I wonder if we have time, may we visit you, your hospital and meeting with community organization, policy makers (if applicable) in San Francisco. The team will be in U.S from 2 - 11 January 2023 and we can have 3 days in San Francisco.
Thank you very much and I am looking forward to hearing from you.

Warm regards,

[redacted]

«Outlook-1496240420.png»
[redacted] Ms, She, Her), MA
Quản lý Chương trình: Hỗ trợ Cộng đồng | Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
SCDI | Số 5 ngách 30 ngõ 165 Thái Hà, P.Láng Hạ, Q.Đống Đa | Hanoi | Vietnam
T +84 (0)24 3572 0679 (số máy lẻ 161) | F +84 (0)4 3572 0680 | M [redacted]
www.scdi.org.vn | www.facebook.com/scdivietnam | https://www.youtube.com/SCDIVietnam
One ream (500 sheets) of paper is equivalent to 5% of a tree. Please consider the trees before printing this email.

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From: [redacted]@ucsf.edu>
Sent: Thursday, December 01, 2022 3:34 PM PST
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>;
[redacted]@ucsf.edu>
Subject: Re: CAGC West Bay Procedure Needs Update

Hello!

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If we continue this trajectory, we are on track to complete ~190 procedure visits for FY2023. In comparison, we completed 163 procedure visits in FY2022 and 164 procedure visits in FY2021.

Best,
~[redacted]

[redacted], MD, MPH, MAS
Assistant Professor of Pediatrics and of Medicine
Divisions of Pediatric Endocrinology and Endocrinology & Metabolism
Assistant Medical Director, Child and Adolescent Gender Center
University of California, San Francisco

Mission Hall
550 16th St, 4th Floor, Box 0434
San Francisco, CA 94143
E-mail: [redacted]@ucsf.edu
She/Her/Hers

From: [redacted]@ucsf.edu>
Sent: Tuesday, October 18, 2022 11:57 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<Tara.Valcarcel@ucsf.edu>
Subject: Re: CAGC West Bay Procedure Needs Update

Hi,

This is fantastic! I appreciate your leadership and advocacy!

Kind regards,

Dr. [redacted], DNP, AC-PNP-BC
Nurse Practitioner
UCSF Pediatric Endocrinology

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Sent: Monday, October 17, 2022 4:05 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>;
[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: CAGC West Bay Procedure Needs Update

Wonderful news!!

Thank you so much!

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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Monday, October 17, 2022 10:50 AM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: CAGC West Bay Procedure Needs Update

All,

Great news! The FPO ERF Committee just approved an additional 1.0 FTE NP for CAGC.

The request will go to the UCSF Labor Management Review Committee next Thursday (10/27) for final approval and will then be pushed through to HR for posting. I'm confident that it'll be posted in the next 2-3 weeks.

Thank you for your patience on this, and please let me know if you have any questions.

Thanks,

[redacted]

From: [redacted]@ucsf.edu>
Sent: Friday, September 30, 2022 3:30 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
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Please let me know if you require any additional information - we've been quite busy and are already ahead of where we were in terms of procedure numbers compared to FY2021. Hopefully this will be important information for the medical center to approve this NP position expeditiously!

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From: [redacted]@ucsf.edu>
Sent: Thursday, December 01, 2022 4:02 PM PST
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: CAGC West Bay Procedure Needs Update

[redacted]

Thanks for reaching out.

The position is still awaiting final approval by the Labor Management Review Committee. Typically, positions that are approved by FPO Executive Leadership sail through LMR approval; however, there are now tighter financial controls for investment requests given the organizational budget deficit. I think we've made a very compelling business case for this position so I'm still optimistic that it will get fully approved and posted soon.

I will let this team know as soon as I have a better sense of timing.

Thanks,

[redacted]

From: [redacted]@ucsf.edu>
Sent: Thursday, December 1, 2022 3:34 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
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Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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Sent: Monday, October 17, 2022 10:50 AM
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Cc: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
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<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
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[redacted], MD, MPH, MAS
Assistant Professor of Pediatries and of Medicine
Divisions of Pediatric Endocrinology and Endocrinology & Metabolism
Assistant Medical Director, Child and Adolescent Gender Center
University of California, San Francisco

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San Francisco, CA 94143
E-mail: [redacted]ucsf.edu
She/Her/Hers

Obtained via CPRA by Judicial Watch, Inc.

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, December 02, 2022 11:42 AM PST
To: [redacted]@ucsf.edu>
Subject: Re: CRC Hire

Hi [redacted],

The travel was smooth, and the conference has been great so far! My lecture is tomorrow morning. I'd definitely like to interview (with you, ideally) the candidate about whom we've previously spoken. I'm fine with you interviewing 2 other applicants on your own. If you end up feeling that one of these other two is more qualified than the original person we've spoken about, than I'd be happy to interview that person as well.

Thanks and best wishes,

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To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
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Thanks,
[redacted]

–

[redacted], ASW
(Pronouns: they/them/theirs)
Clinical Research Coordinator
UCSF Child & Adolescent Gender Center
[redacted] | [redacted]@ucsf.edu

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From: [redacted]@ucsf.edu>
Sent: Friday, December 02, 2022 11:55 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: CRC Hire

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Thanks!
[redacted]

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, December 02, 2022 11:58 AM PST
To: [redacted]@ucsf.edu>
Subject: Re: CRC Hire

Thanks

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Professor of Pediatrics
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Endocrine Reviews, 2022, **XX**, 1–47
https://doi.org/10.1210/endrev/bnac019
Advance access publication 10 August 2022
Review

History of Adrenal Research: From Ancient Anatomy to Contemporary Molecular Biology

Walter L. Miller[1] **and Perrin C. White**[2]

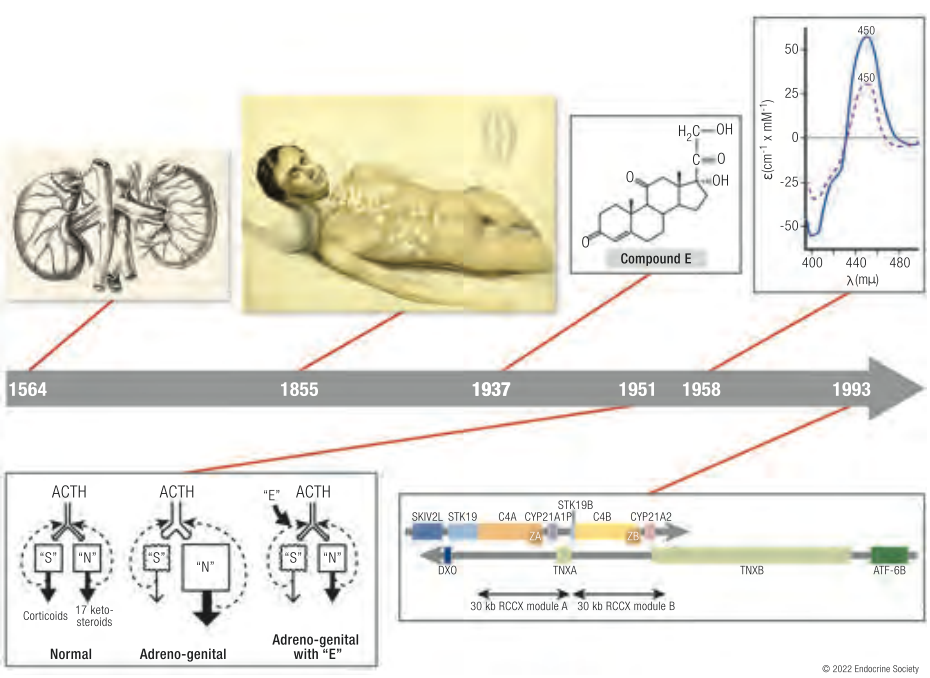
[1]Department of Pediatrics, Center for Reproductive Sciences, and Institute for Human Genetics, University of California, San Francisco, CA, USA
[2]Division of Pediatric Endocrinology, University of Texas Southwestern Medical Center, Dallas, TX, USA

Correspondence: Walter L. Miller, MD, Distinguished Professor of Pediatrics, Emeritus, University of California, San Francisco, San Francisco, CA 94143. Email: wlmlab@ucsf.edu

Abstract

The adrenal is a small, anatomically unimposing structure that escaped scientific notice until 1564 and whose existence was doubted by many until the 18th century. Adrenal functions were inferred from the adrenal insufficiency syndrome described by Addison and from the obesity and virilization that accompanied many adrenal malignancies, but early physiologists sometimes confused the roles of the cortex and medulla. Medullary epinephrine was the first hormone to be isolated (in 1901), and numerous cortical steroids were isolated between 1930 and 1949. The treatment of arthritis, Addison's disease, and congenital adrenal hyperplasia (CAH) with cortisone in the 1950s revolutionized clinical endocrinology and steroid research. Cases of CAH had been reported in the 19th century, but a defect in 21-hydroxylation in CAH was not identified until 1957. Other forms of CAH, including deficiencies of 3β-hydroxysteroid dehydrogenase, 11β-hydroxylase, and 17α-hydroxylase were defined hormonally in the 1960s. Cytochrome P450 enzymes were described in 1962-1964, and steroid 21-hydroxylation was the first biosynthetic activity associated with a P450. Understanding of the genetic and biochemical bases of these disorders advanced rapidly from 1984 to 2004. The cloning of genes for steroidogenic enzymes and related factors revealed many mutations causing known diseases and facilitated the discovery of new disorders. Genetics and cell biology have replaced steroid chemistry as the key disciplines for understanding and teaching steroidogenesis and its disorders.

Graphical Abstract



Key Words: Addison disease, adrenal hyperplasia, cortisone, cytochrome P450, genetic disease, steroid

Abbreviations: ACTH, adrenocorticotropic hormone; APS, autoimmune polyglandular syndrome; 3β-HSD, 3β-hydroxysteroid dehydrogenase; CAH, congenital adrenal hyperplasia; cAMP, 3′,5′-cyclic adenosine 5′-monophosphate; DAX-1, DSS-AHC critical region on the X chromosome, gene 1 (also termed NR0B1); DHEA, dehydroepiandrosterone; DHEAS, dehydroepiandrosterone sulfate; DOC, 11-deoxycorticosterone; 17KS, 17-ketosteroids; 17OHP, 17-hydroxyprogesterone; 11OHD, 11-hydroxylase deficiency; 21OHD, 21-hydroxylase deficiency; HLA, human leukocyte antigen; Kb, kilo base pairs; PAPSS2, 3′-phosphoadenosine 5′-phosphosulfate synthase 2; POR, P450 oxidoreductase; P450, cytochrome P450; NADPH, reduced nicotinamide adenine dinucleotide phosphate; SF-1, steroidogenic factor 1 (also termed NR5A1 and Ad4BP); StAR, steroidogenic acute regulatory protein; WLM, Walter L. Miller; PCW, Perrin C. White; VLCFA, very long chain fatty acids.

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The history of the adrenal closely parallels the history of Western medical and biological science and vividly illustrates how investigators of different eras formulated their questions and sought answers. The philosophical ruminations of Aristotle and Galen gave way to Renaissance anatomy and then to clinical observation, but scientific understanding of the adrenal required a marriage of clinical medicine with basic science: the chemistry of steroid hormones (1920s-1950s) and the revolution in molecular genetics (1980s-2000s). Hundreds of investigators writing thousands of papers have provided today's detailed but still incomplete knowledge of the adrenal. Herein we trace this history, concentrating on the adrenal cortex, emphasizing how incisive observation and the application of the newest available scientific techniques have advanced knowledge.

Antiquity to 1800: Finding the Adrenal

The early history of adrenal discovery and research has been reviewed previously (1-6) and is summarized briefly here. It appears that ancient observers did not identify the adrenal as a structure distinct from perinephric fat. In Homer's *Iliad*, Book 21, Achilles slew Asteropaios with a single sword stroke: "Near the navel he slashed his belly; all his bowels dropped out uncoiling to the ground" (line 210). Achilles then cast the body into the river Xanthos (Skamander): ". . . to lie in the sand, where the dark water lapped at it. Then eels and fish attended to the body, picking and nibbling kidney fat away" (lines 236-238) (7). The familiar King James version of the Bible contains 2 verbatim identical passages (Leviticus 3:4 and 4:9) referring to animal sacrifice ". . . the two kidneys, and the fat that is on them, which is by the flanks . . . ." The great physician of second-century Rome, Galen of Pergamon (circa 130-201), may have been the first to mention the adrenal: he described "loose flesh" atop the left kidney and described the vein going to the "capsule of the right kidney." "For when the vein first appears outside the liver, before reaching the loin, being still high, at its own right side, it sends to the capsule of the right kidney and the bodies around this sometimes spiderweb-like, sometimes hairlike, and sometimes thicker contributions" (8).

The Renaissance brought the scientific study of anatomy. Unpublished anatomical sketches by Leonardo da Vinci in 1485-1490, in the Royal Collection Trust and exhibited in Scotland in 2013 (9), show supra-renal structures that might have been adrenals or perinephric fat (Fig. 1), but Leonardo did not discuss what he was drawing, and he made no effort to inform the world of his observation. Viselius' famous (and well-illustrated) "De Humanis Corporis Fabrica" (1543) shows the kidneys without adjacent adrenals. The first published description of the adrenal gland was provided by Bartolomeo Eustachio (circa 1520-1574), who described the adrenals as "glandulae quae renibus incumbent" (glands lying on the kidney) in his book *Opuscola Anatomica*, published in 1564. Eustachio states the adrenals were "diligently overlooked by other anatomists" (perhaps referring to Vesalius) and describes them clearly: "Both kidneys are capped on the extremity towards the cava by a gland. Both are connected with a fold of the peritoneum in such a way that one, if he is not very attentive, does really overlook them, as if they were not present. Their shape resembles that of the kidneys . . . sometimes one is bigger, sometimes another . . . early anatomists and those who write ample treatises on this art in our days failed to detect them" (2, 3). Eustachio had planned an anatomical "magnum opus" that was to rival that of Vesalius' and, with Roman artist Pier Matteo Pini, had prepared 47 engraved copper plates to illustrate the text, but Eustacchio died before completing this project. The first 8 plates were published in the preliminary *Opuscula Anatomica*, including a clear illustration of the adrenals sitting atop the kidneys (Fig.

ESSENTIAL POINTS

- The functions of the adrenal were inferred from the adrenal insufficiency syndrome described by Addison and from the Cushingoid obesity and virilization that accompanied many adrenal malignancies.
- Medullary epinephrine was the first hormone to be isolated (1901), and numerous cortical steroids were isolated between 1930 and 1949.
- Cases of congenital adrenal hyperplasia (CAH) were reported in the 19th century, but the causative biosynthetic defects were defined hormonally in the 1950s and 1960s.
- The treatment of arthritis, Addison's disease, and CAH with cortisone in 1950 revolutionized clinical endocrinology and steroid research.
- Great advances in the understanding of steroidogenesis and the various forms of CAH were achieved through steroid chemistry.
- Understanding the genetic and biochemical basis of adrenal disorders advanced very rapidly from 1984 to 2004 with the cloning of the genes for steroidogenic enzymes and related factors, revealing a vast array of mutations in a comparatively small number of genes and facilitating detailed understanding of known diseases and discovery of new disorders.
- Genetics and cell biology have replaced steroid chemistry as the key disciplines for understanding and teaching steroidogenesis and its disorders.

Figure 1. A sketch by DaVinci ca. 1485-1490 of the kidney with an apparent adrenal in the correct anatomic location (RCIN 912597, in the public domain at https://commons.wikimedia.org/wiki/File:Leonardo_da_Vinci_-_RCIN_912597,_The_major_organs_and_vessels_c.1485-90.jpg).

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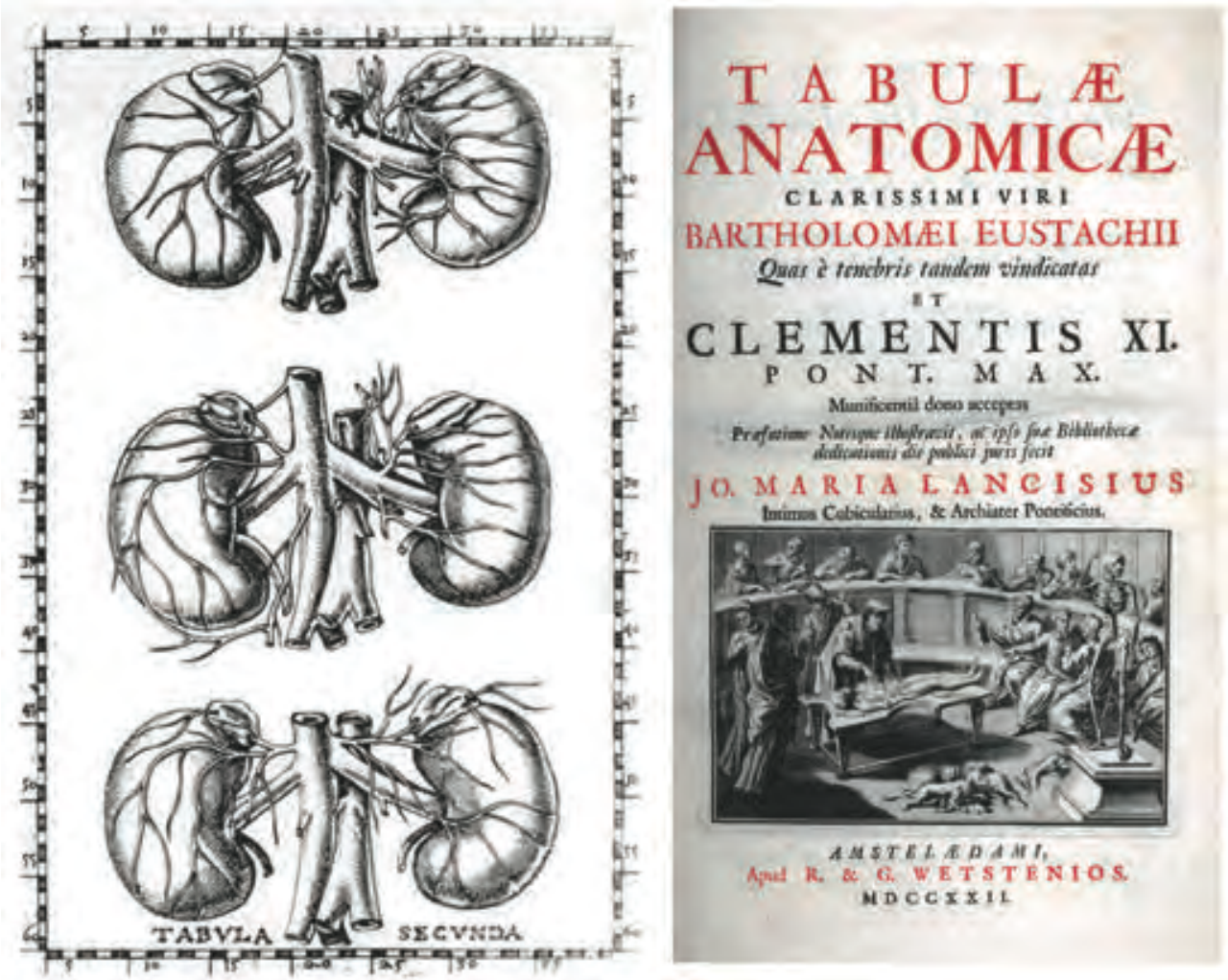

Figure 2. *Left*, Plate 2 from Eustacchio's "Opuscola Anatomica," as reproduced by JM Lancisi in 1714 as "Tabulae Anatomicae" (image from page 64 of Lancisi's volume, in the public domain at https://search.lib.virginia.edu/sources/uva_library/items/u3606395?idx=0&page=64. *Right*, Faceplate of Lancisi's book (image captured online at https://en.wikipedia.org/wiki/Bartolomeo_Eustachi).

2a). Pini's engraved plates found their way to the papal library, where they remained for about 150 years, until Pope Clement XI gave them to his personal physician, Giovanni M. Lancisi, who published all 47 plates, plus his own notes, in 1714 as *Tabulae Anatomicae Clarissimi viri Bartholomaei Eustacci* (Fig. 2b). Eustachio's book was not circulated widely, and most anatomists first encountered his work through Lancisi's book. Although Lancisi credits Eustachio's discovery of the adrenal, some authors have reported that this was the first publication of Pini's engravings (10). D. Lynn Loriaux, who was president of the Endocrine Society in 1995, published his personal account of viewing Eustachio's book at the Vatican in 1977 or 1978 (11).

Eustachio's work was not widely known; in 1627, Giulio Cesare Casseri (1552-1616) published an illustration of the adrenals atop the kidneys, which may have been the first widely seen illustration of the correct anatomy (Fig. 3) (12). Between 1650 and 1750, multiple anatomists described the adrenals as hollow, fluid-filled organs. The first of these may have been Danish anatomist Caspar Bartholin the Elder (1585-1629), who described the adrenals as filled with "black bile," probably referring to the medulla undergoing postmortem autolysis (13). His son, Thomas Bartholin, who followed his father as professor of anatomy at the University of Copenhagen, described different anatomic appearances of the adrenal (14), including the hollow adrenal filled with "black bile" (Fig. 4). Bartholin the Elder was the grandfather of Caspar Bartholin the Younger (1655-1738), who described Bartholin's glands. Others also described an adrenal filled with "black bile," including Johann Vesling (15), Thomas Wharton (16), and Antonio Molinetti (17); these and other anatomists offered fanciful theories concerning adrenal function, but without evidence (1). There also were "adrenal deniers": Piccolomini (1586) claimed that the adrenals were rare renal "excrescences" (outgrowths), similar to supernumerary digits (2), and Andre du Laurens, physician to Henry IV of France, wrote in 1640 that "Eustachius claims to find a gland above the kidneys. Sometimes we saw that too; often, however, we stated that there was no such gland" (3) (deniers of science have always been with us). In 1805 Georges Cuvier, professor of animal anatomy at the Museum of Natural History in Paris, established that the adrenal is a solid organ (lacking a hollow cavity filled with "black bile") and distinguished the cortex from the medulla but provided no insight into their functions (18). In 1831, Friedrich Arnold, professor of anatomy in Heidelberg,

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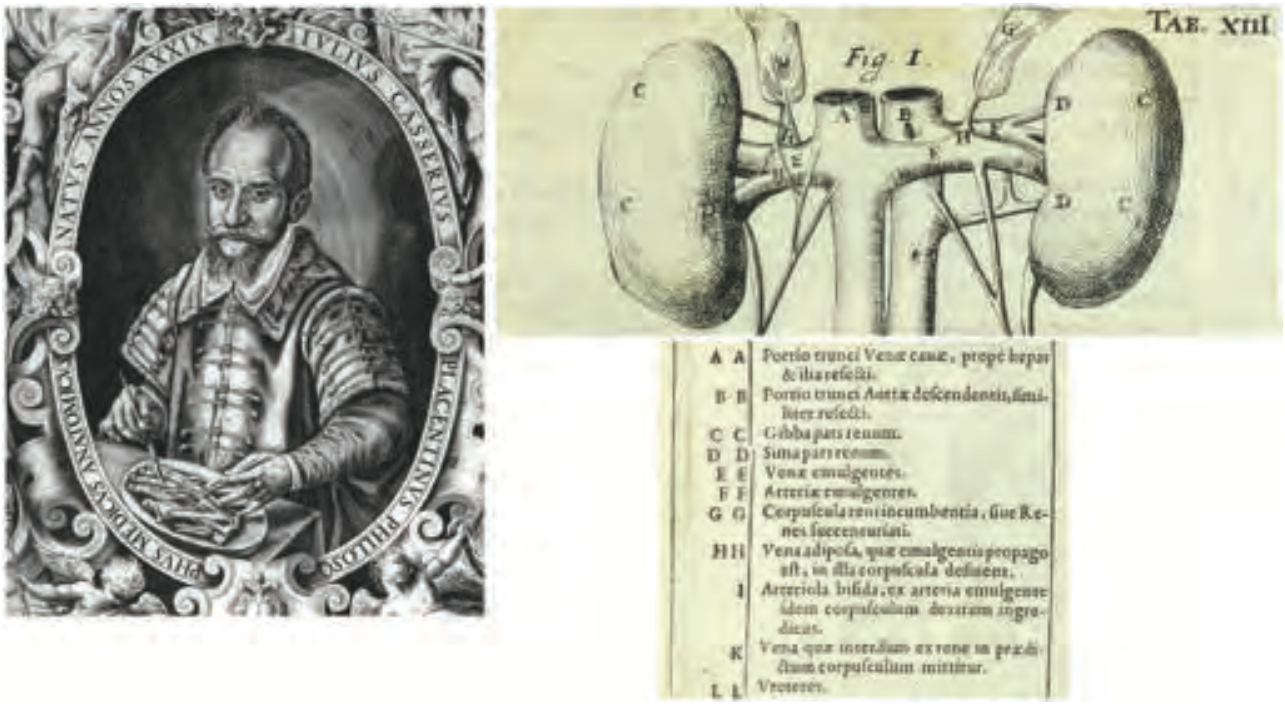

Figure 3. *Left,* Giulio Cesare Casseri, from the frontispiece of his book *Tabulae Anatomica* (Deuchinus, 1627) (in the public domain at https://en.wikipedia.org/wiki/Giulio_Cesare_Casseri#/media/File:Casserius.png). *Right,* Casseri's illustration of the kidneys, featuring the adrenals, indicated by "G" and labeled "corpuscula reni incumbentia sive Renes succenturiati" (renal corpuscles lying on or above the kidney) (images from page 174 of Casseri's volume in the public domain at https://archive.org/details/tabulaeanatomica00cass/page/174/mode/2up).

showed that the fetal adrenal developed from the embryonic Wolffian ducts (19). Based on histologic studies, the terms "cortex" and "medulla" were introduced in 1836 (20) but without functional insight.

1697-1889: Discovering Adrenal Functions

The discovery of the adrenals offered no clues to their function, and as detailed by Shumacker, between the time of Eustaccio and Casseri until the time of Addison, at least 50 publications offered fanciful theories, without evidence (1). In 1716 the Academy of Sciences of Bordeaux sponsored an essay competition to discover "Quel est l'usage des glandes surrenales?" ("What is the use of the suprarenal glands?"). The Baron Montesquieu judged the competition but decided none of the entries merited the prize (21). As described by Schäfer, Montesquieu concluded "Perhaps chance may some day effect what all these careful labours have been unable to perform" (22).

Disease often leads to functional insights, and adrenal tumors suggested the adrenal influenced multiple systems. In 1697, Henry Sampson described the clinical course, death, and autopsy of a 6-year-old girl who died in 1688 (23); a 21st-century reading indicates she was virilized, Cushingoid, and died from metastatic adrenocortical carcinoma and a probable renal vein thrombosis (24). Sampson apparently did not know about the adrenal, although other 17th-century writers had mentioned it. In 1809 Cooke reported a similar case in another 6-year-old obese, virilized girl, having a tumor "intimately blended" into the left kidney, but made no mention of the adrenals (25); Cooke did not cite Sampson or any other reports. In 1865, JW Ogle reported the death and autopsy of a 3-year-old girl with obesity and poor growth who had a $2^{2}/_{16}$ pound left adrenal mass with at least one hepatic metastasis (26). TC Fox reported a similar course in a 2-year-old girl in 1885; he identified a 1½ pound left adrenal tumor with "secondary growths" in the mesenteric lymph nodes and cited reports of 5 other cases (27). Many of these early cases also had venous thromboses. Bulloch and Sequira reviewed the pathology literature concerning adrenal tumors in 1905, compiling 12 cases (28). These authors notably included early cases of probable CAH, clearly noting that the adrenal could profoundly influence the sexual phenotype. Thus, by the beginning of the 20th century, it was apparent that the adrenal, presumably through some form of hyperactivity, could influence body mass, growth, and virilization, but how this happened was unclear.

The role of adrenal insufficiency was first studied in the mid-18th century. The first reports that the adrenals were physiologically important came from Thomas Addison. In describing probable pernicious anemia, he noted that 3 deceased patients "had a diseased condition of the suprarenal capsules"; one had malignancy, one atrophy and one had 'struma' (probable tuberculosis) (29). He followed this with a more detailed description of 11 patients, of whom 6 had adrenal tuberculosis; some others may have had autoimmune adrenalitis (Fig. 5). His clinical description of adrenal insufficiency remains clear and lucid today: "The discoloration pervades the whole surface of the body, but is commonly most strongly manifested on the face, neck, superior extremities, penis, scrotum, and in the flexures of the axillae and around the navel . . . The leading and characteristic features of the morbid state . . . are, anaemia, general languor and debility, remarkable feebleness of the heart's action, irritability of the stomach, and a peculiar change of the colour in the skin, occurring in connection with a diseased condition of the suprarenal capsules" (30).

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Figure 4. Thomas Bartholin's varied adrenal anatomy. The top figure shows hollow, ovoid adrenals, supporting the notion that the adrenals were filled with "black bile"; a variant of this illustration was also published by Johann Vesling (1647) [from (14)] (in the public domain at http://mateo.uni-mannheim.de/camenaref/bartholin/bartholin1/jpg/s123.html).

Aware of Addison's work, in 1856 the peripatetic Charles-Edouard Brown-Sequard (1817-1894) wrote 2 papers showing that adrenalectomy caused death (in dogs), inferring that this was due to lack of an adrenal secretion (31). Brown-Sequard wrote 3 additional papers describing the lethal effects of adrenalectomy in 1857 and 1858 (32-34) but others questioned his results [see (35)]; it was not until 1908 that the medical world generally agreed that the adrenals were necessary for life (22). Most famously (or infamously), in 1889 Brown-Sequard reported "rejuvenated sexual prowess" after injecting himself with testicular extracts (36). This was certainly a placebo effect, as recapitulation of Brown-Sequard's procedures yield a fluid with insignificant amounts of steroids [reviewed in (37)]. Brown-Sequard's "organotherapy" may have been quackery, but it inspired other research work. In 1891 George Murray injected an extract of sheep thyroid into a woman with myxedema (38), and hypothyroidism was successfully treated with oral desiccated thyroid into the 1960s. Many investigators worked on the isolation of sex steroids; for example, TF Gallagher and Fred Conrad Koch (for whom the Endocrine Society's most prestigious Laureate Award is named) were early leaders in developing the cock's comb assay for androgens (39) and in isolating "the testicular hormone" (40). The history of testosterone is reviewed elsewhere (41-43).

Nineteenth-Century Reports of CAH

Because it is a relatively common disease, there must have been individuals who survived with virilizing non-salt-losing CAH throughout history, but the earliest probable case may be the one reported anonymously in *The Lancet* in 1833, which reiterates a case initially reported in *Journal Hebdomadaire* by M. (monsieur) Bouillaud: "A person named Valmont, aet. 62, a widower, of small stature, was admitted on the 6th of April into the cholera wards of La Pitie, and died next morning. As Valmont appeared to possess all the attributes of the male sex when received into the wards, we were not a little astonished, when the abdominal organs were opened, at finding in the cavity of the pelvis a perfectly-formed womb!" The anatomic examination was detailed by a M. Manec, who observed "a penis, perfectly formed, of middling size" with hypospadias (Fig. 6). He found no testes but "two ovaries, of the same size as in a girl of 16, and two Fallopian-tubes, with their extremities opening into the uterus, as in a perfect female." There is a detailed description of the uterus, vagina, and the urethra opening "surrounded by a perfect prostate gland" into the vagina; the adrenals were not mentioned. The anonymous British author in *The Lancet* concludes that "hermaphrodism can no longer be disputed" and that "[i]n many countries, modifying clauses must be, consequently, introduced into the laws relative to the civil state, the succession of property, and the administration of criminal justice, in order to regulate the position, attributes, and social duties of these intermediate beings" (44).

The best-described early case was reported by Luigi de Crecchio (1832-1894), a forensic pathologist ("professor of legal medicine") in Naples, who reported the postmortem anatomical findings in Giuseppe Marzo, showing that Marzo had a uterus, Fallopian tubes, and ovaries (45) (Fig. 7). De Crecchio investigated Marzo's life, including interviews with family and associates. Marzo's sex assignment at birth was female (with the given name Maria Giuseppa) but was changed at age 4 when a surgeon determined Marzo was a boy with undescended testes. Marzo lived as a man, was twice treated for gonorrhea, never married, and died in an apparent Addisonian crisis at age 44. De Crecchio noted that Marzo had very large adrenals but thought Marzo's findings indicated a disorder of puberty, and he did not discuss a possible role for the adrenal hyperplasia. A complete translation and exegesis of De Crecchio's paper was published in 2015 (46).

Possibly the earliest report of familial CAH was in 1886 from John Phillips, "Physician to the British Lying-In Hospital; Senior Assistant Physician, Chelsea Hospital for Women." He reported the delivery of a woman's ninth child; 4 of the previous children had "spurious hermaphroditism" (a

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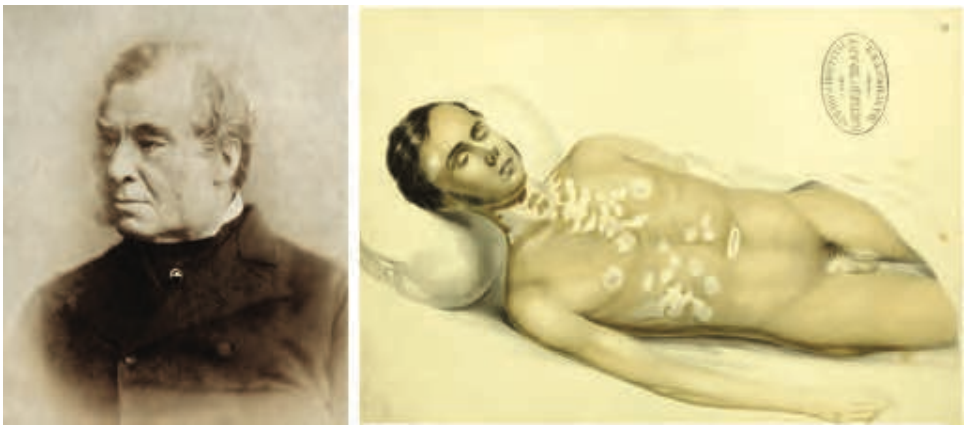

Figure 5. *Left,* Thomas Addison (photographer unknown); in the public domain at (https://commons.wikimedia.org/w/index.php?curid=35152865). *Right,* Reproduction of Plate 11, showing a postmortem "sketch" of "Mr. S" from Thomas Addison's 1855 monograph (30) (https://wellcomecollection.org/works/xsmzqpdw). Most of the patients described by Addison had tuberculous adrenalitis, but the patchy vitiligo and scant pubic hair illustrated here suggests autoimmune polyglandular syndrome type 2.

term that preceded "pseudohermaphroditism," both referring to individuals whose external genital anatomy did not correspond to the physician's expectations based on the gonadal anatomy). The 4 affected children "gradually wasted" and died at 24, 59, 40, and 19 days of age. The last of these children is described in detail, with clitoromegaly, a urogenital sinus, and a palpable uterus. At the postmortem examination "the pelvic organs were found to be entirely female" "with the kidneys and suprarenal capsules (which were very large) . . ." (47). This history strongly suggests salt-wasting CAH in these 4 infants, but the hereditary basis of CAH was vigorously debated into the 1950s. The proximity of the adrenal and kidney and the resemblance of renal cell cancer cells to adrenocortical cancer cells has led to confusion, as renal-cell cancers were once believed to originate from aberrant adrenal tissue. In 1883 Grawitz described renal-cell cancers and termed them "struma lipomatodes aberrata renis" (48). His theory that these renal tumors arise from adrenal tissue led to the common term "hypernephroma," a misleading term that persisted into the mid-20th century.

These early reports of CAH contributed to the understanding that the adrenals can influence sexual phenotypes. In 1912 Ernest Glynn, a pathologist in Liverpool, reviewed the literature concerning adrenal tumors that influenced the patient's sexual phenotype (49). His Table I lists 17 cases of "Sex Abnormalities in Children associated with Adrenal Hypernephroma verified post mortem" and 6 cases of "Adrenal Hypernephroma in Young Adult Females associated with Changes in Sex Characters"; his Table II lists 6 cases of "Male Sex Characters in Adult Females Associated with Adrenal Hypernephroma." Glynn's Tables I and II list virilizing adrenal tumors, although his case #22 (on page 166) was most likely a case of CAH. Under the heading of "Pseudohermaphroditism" he says, "The occurrence of hyperplasia of the adrenal gland, or of accessory adrenals with some cases of pseudo-hermaphroditism, is another example of the association between the adrenal and sex"; he then summarizes 9 cases, several of whom (including 2 siblings) certainly had CAH. Glynn's Table III lists 13 cases "of the Association of Pseudo-hermaphroditism, particularly Feminine, with Bilateral Hyperplasia of the Adrenal Gland"; most of these individuals clearly had CAH. Glynn correctly concluded "The adrenal cortex and medulla have a different development and different functions; the former is especially connected with growth and sex characters, the latter with blood pressure" and "In pseudo-hermaphroditism the sex abnormalities are mainly congenital, and the adrenal lesions, if any, are bilateral hyperplasia or cortical rests" (49).

In 1912 Alfred Gallais presented his doctoral thesis to the Faculté de Medécine de Paris (Sorbonne), in which he describes "le Syndrome Génito-Surrénal" (50). His work summarizes a hodge-podge of clinical reports of people with adrenal tumors and Cushing disease, and some with probable CAH, and does not attempt to categorize the cases as does Glynn, but it is remembered as the origin of the term "adrenogenital syndrome." Gallais was widely cited in the early 20th century, and the term persisted into the late 20th century. For example, in 1940, Marks et al reported "adrenal obesity" in a profoundly Cushingoid 10-month-old girl (Fig. 8) with adrenogenital syndrome caused by an adrenal adenoma found at autopsy (51). Their accompanying review of 24 cases of "obesity in children with tumors of the adrenal cortex" found a 21:3 preponderance of girls and a 14:10 preponderance of carcinomas; of the 6 who underwent surgical removal of the tumor, only 2 survived. A case report and literature review in 1946 described 54 children with adrenogenital syndrome caused by virilizing adrenal carcinomas (52), and a 1953 review of adrenogenital syndrome stated the term should only be applied to adult patients with adrenal hyperplasia or adrenal tumors, although some had ovarian tumors (possibly adrenal rests) or apparent polycystic ovary syndrome (PCOS) (53). Fortunately, the term "adrenogenital syndrome" has been abandoned by contemporary endocrinology.

Finding the First Adrenal Hormone—Epinephrine

The first adrenal hormone to be isolated, purified, characterized chemically, and synthesized in vitro was epinephrine. Early adrenal investigators had difficulties in differentiating the effects of the medulla and cortex. This important chapter in adrenal history has been reviewed in detail elsewhere (54, 55) and is summarized here.

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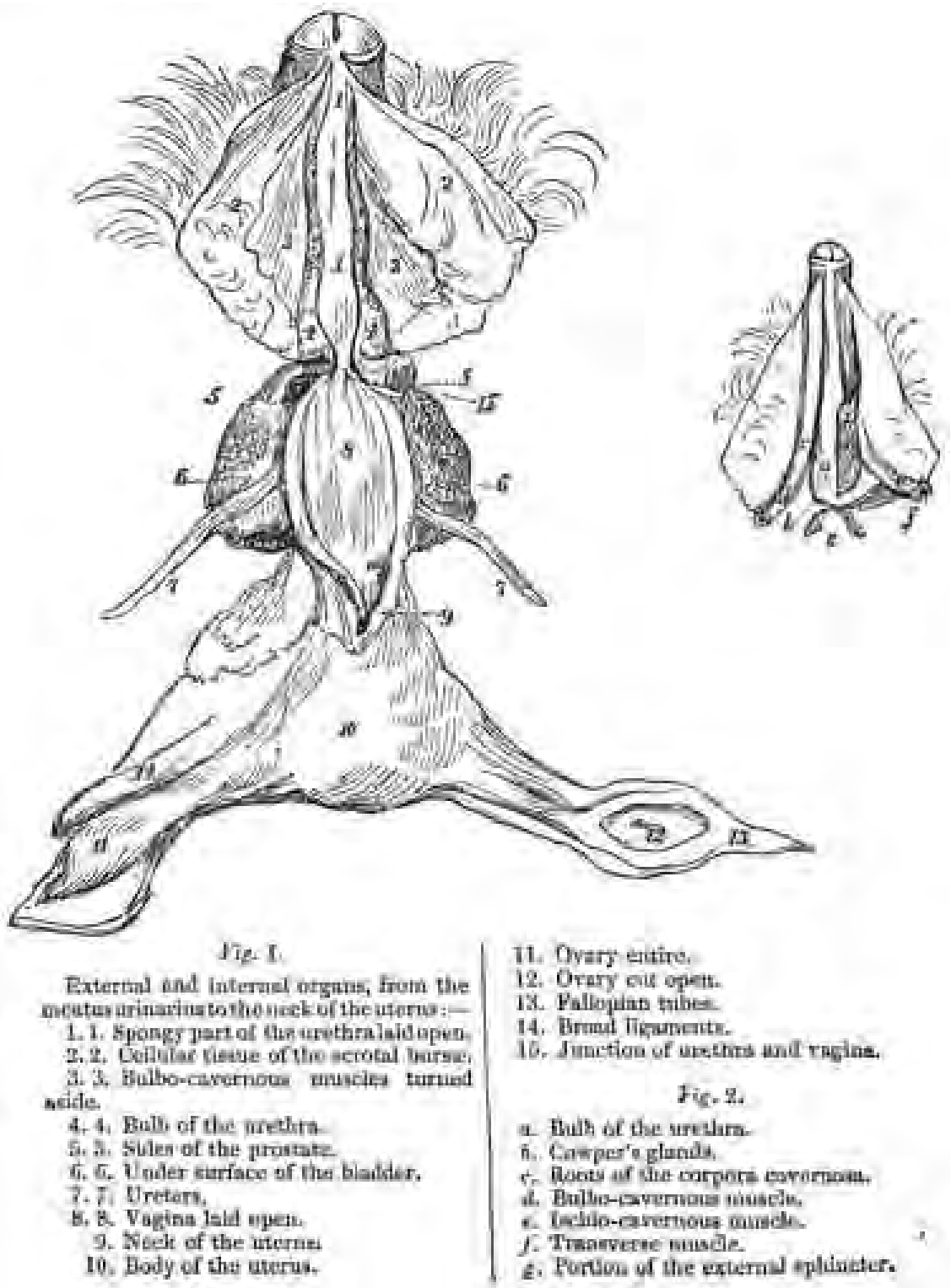

Fig. 1.

External and internal organs, from the meatus urinarius to the neck of the uterus:—
1. 1. Spongy part of the urethra laid open.
2. 2. Cellular tissue of the scrotal bursæ.
3. 3. Bulbo-cavernous muscles turned aside.
4. 4. Bulb of the urethra.
5. 5. Sides of the prostate.
6. 6. Under surface of the bladder.
7. 7. Ureters.
8. 8. Vagina laid open.
9. Neck of the uterus.
10. Body of the uterus.
11. Ovary entire.
12. Ovary cut open.
13. Fallopian tubes.
14. Broad ligaments.
15. Junction of urethra and vagina.

Fig. 2.

a. Bulb of the urethra.
b. Cowper's glands.
c. Roots of the corpora cavernosa.
d. Bulbo-cavernous muscle.
e. Ischio-cavernous muscle.
f. Transverse muscle.
g. Portion of the external sphincter.

Figure 6. Autopsy of genitourinary structures of a virilized female patient with congenital adrenal hyperplasia in 1833 (44). The larger illustration, labeled "Fig. 1" is accompanied by a listing of 15 numbered structures; notable structures include (1) the urethra immediately inferior to the glans penis; (6 and 7) bladder and ureters, respectively; (8) vagina; (10) uterus; (11,12) ovaries; (11) 1 of the Fallopian tubes. The smaller illustration, labeled "Fig. 2" is accompanied by a listing of 7 structures labeled a though g, showing the urethra, Cowper's glands, corpora cavernosa, and accompanying musculature (in the public domain at https://www.sciencedirect.com/science/article/abs/pii/S0140673602937700).

In 1856 in Paris, Alfred Vulpian (1826-1896) discovered the 2 colorimetric reactions of the adrenal medulla that ultimately identified epinephrine (ferric chloride turns medullary extracts green, whereas iodine turns it "rose-carmine"). He noted this reaction with the adrenals of multiple mammals and birds and that blood from the adrenal vein, but not other veins, gave the same reactions, from which he inferred that the responsible substance is secreted into the circulation

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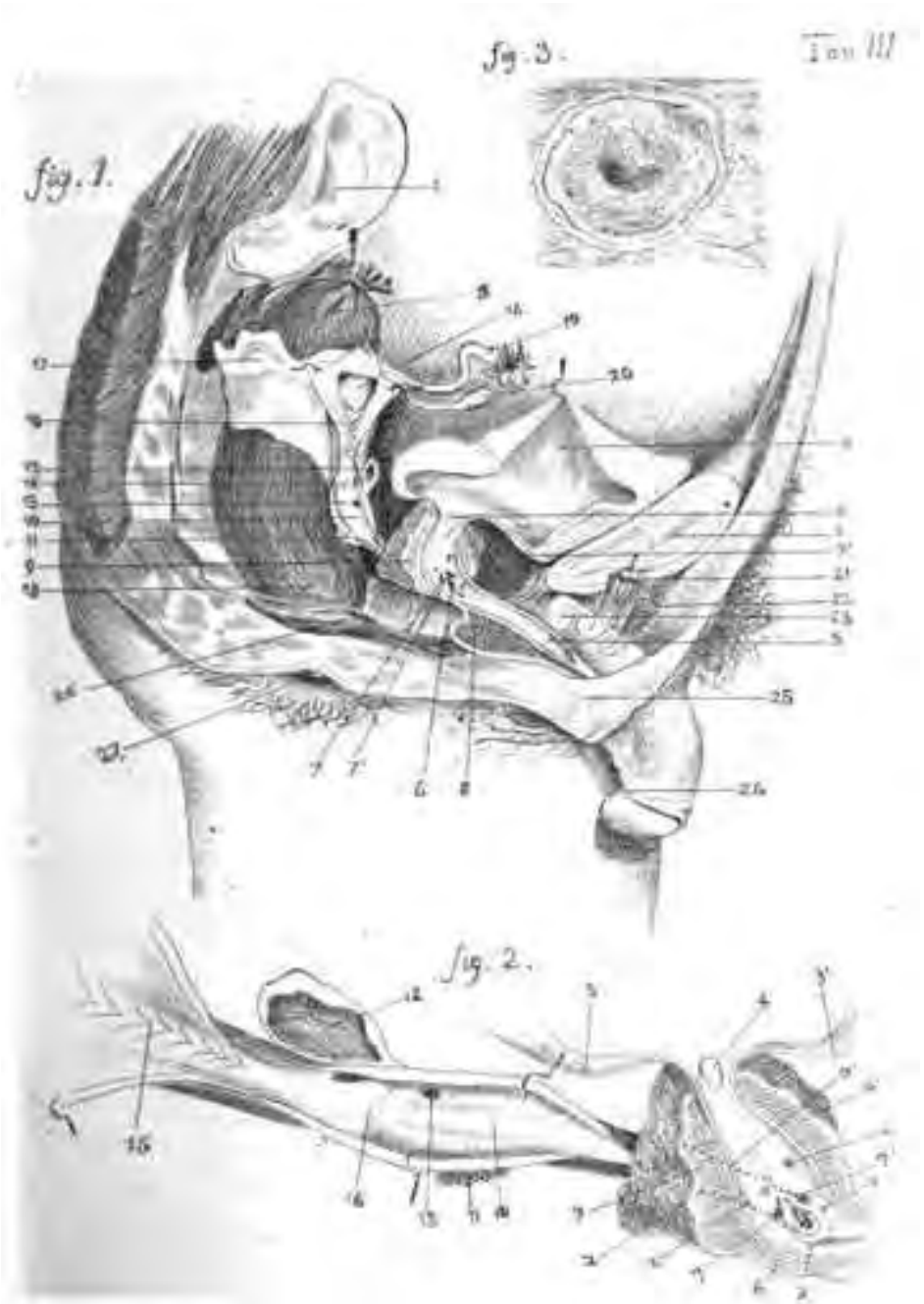

Figure 7. Plate 3 from De Crecchio's paper (45), containing 3 drawings. Fig. 1: longitudinal view of the pelvic contents. Some relevant structures are: 5. Urethra (opened). 10. Vagina. 14. Uterus (opened). 15. Cervix. 17. Right broad ligament, containing the right ovary and Fallopian tube. 19. Left Fallopian tube and fimbriae. 20. Left ovary. 23. Right corpus cavernosum (cut). 24. Urethral meatus. Fig. 2: connection of the vagina to the prostatic urethra; numbers as in Fig. 1; for details see (46). Fig. 3: drawing of a Graafian follicle from Marzo, as seen microscopically at 620× (in the public domain; from the University of Michigan Library, http://hdl.handle.net/2027/mdp.39015013772457).

(56). Vulpian became dean of the faculty of medicine at the University of Paris and a member of the French Académie des Sciences; a statue of him adorns the Rue de l'École de Médicine in Paris. The reaction of medullary extracts with chromic acid was reported by Bartholdus Werner in 1847 and described in detail by Jacob Henle in 1865 (57); this led to the terms "chromaffin reaction" and medullary "chromaffin cells" introduced by Alfred Kohn in 1902 (58). In 1885, Carl Krukenberg noted that the color reaction of pyrocatechol resembled that the color reaction of adrenal extracts (59), eventually leading to the term "catecholamines."

In 1894, George Oliver and Edward S. Schäfer reported that intravenous administration of a glycerin extract of calf adrenals caused vasoconstriction and hypertension in dogs (60, 61). In 1908, Schafer said, "Perhaps within the next few years a successor of mine in this lectureship will be able to put before you as much positive knowledge regarding the cortex as we now possess regarding the medulla, the function of which seemed, no more than fifteen years ago, as obscure as that of the cortex appears at present. And with the hope that this obscurity may speedily be removed, I cannot do better than terminate my lecture." (22). Shortly thereafter,

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Figure 8. 10½-month-old girl with "adrenogenital syndrome" and "adrenocortical obesity" caused by a 3 cm diameter, 12 g right adrenal adenoma (51) (in the public domain at https://jamanetwork.com/journals/jamapediatrics/fullarticle/1178993).

William Horatio Bates, an ophthalmologist in New York, reported that a sheep adrenal extract whitened the conjunctiva of the eye, indicating a vasoconstrictor effect (62) and which others subsequently used as a bioassay for epinephrine. In Philadelphia, Solomon Solis-Cohen suggested that adrenal extracts might be useful therapeutic agents for hay fever and asthma (63, 64), accelerating pharmaceutical interest in the adrenal.

The 3 leading investigators aiming to purify the adrenal hypertensive agent were Benjamin Moore in London, John Jacob Abel at Johns Hopkins, and Otto von Fürth in Strassburg (then in Germany) (65). Abel reacted adrenal extracts with benzyl chloride to prepare an agent that raises blood pressure; he termed this "epinephrin" (no "e") (66). He proposed the empirical formula $C_{17}H_{15}NO_4$ for "the active principle of the suprarenal capsule" (ie, "epinephrin") (67). Unfortunately for Abel this was incorrect, as his formula included the benzyl group added in the purification, and benzoylation yielded inactive material. These investigators opposed one another vigorously, preparing different extracts, performing different derivatization procedures, proposing different chemical compositions, and claiming each other's results were incorrect.

On July 21, 1900, working in the laboratory of Jokishi Takamine on Manhattan's 109th Street West under a contract with Parke, Davis & Co., Keizo Uenaka (Wooyenaka), Takamine's lab technician, first purified "adrenalin" (no "e") from aqueous adrenal extracts furnished by Parke-Davis. Uenaka used procedures similar to those he had used for ephedrine with Nagayoshi Nagai in Tokyo and made the key observation that he had to avoid oxidation (68). When administered to the eye of an unfortunate mouse that had been caught in the lab, the conjunctiva lost its color, indicating vasoconstriction, much as Bates had described. Uenaka then obtained "adrenalin" crystals; he scaled up his procedures, extracting 10 g of crystals from 10 kg of bovine adrenals. On Oct 13, 1900, Uenaka applied a drop of 1:1000 dilution to his own eye and observed vasoconstriction (0.1% epinephrine remains in use today). On Nov 5, 1900, Takamine accepted the suggestion of Dr. Norton Wilson to call the material "adrenalin" (no "e") and applied for a patent. Takamine published this work in December 1901 (69, 70), estimating the empirical formula to be $C_{10}H_{15}NO_3$. Working at Parke-Davis independently of Takamine, Thomas B. Aldrich, who had worked with Abel, determined the correct formula of $C_9H_{13}NO_3$, but says in his paper that his material is the same as Takamine's (71). Takamine registered the trade name "adrenalin," and Parke-Davis began sales of "Adrenalin Chloride Solution," both in 1901. Adrenalin was advertised for "bloodless surgery", and commercial success was immediate.

In the late 19th century America was awash with "patent medicines" (often termed "snake oil") that were of dubious value; patents were pursued by charlatans and quacks, not by "real doctors" or "legitimate" pharmaceutical companies. At this time, existing precedent has already drawn the line at patenting natural objects or laws of nature. Takamine had previously obtained US Patent 525 823 for a "Process for making diastatic enzyme," a yeast preparation that he had devised for the brewing industry but eventually sold as a digestive aid, first marketed in 1895 as "Taka-Diastase" (55). Takamine had licensed this financially successful patent to Parke-Davis. He similarly applied for a US Patent for "adrenalin" in 1901 and was granted US Patent no. 730 175 "Process of obtaining products from suprarenal glands" on June 2, 1903 (72). Adrenaline rapidly became a commercial success, and others marketed equivalent products: Takamine's patents were challenged in court by HK Mulford Company. In a key ruling by Judge Learned Hand in the US Circuit (District) Court for the Southern District of New York, Takamine's patents were upheld (73). Judge Hand, who had been on the bench for only 24 months, wrote, "But, even if it were merely an extracted product without change, there is no rule that such products are not patentable. Takamine was the first to make it available for any use by removing it from the other gland-tissue in which it was found, and, while it is of course possible logically to call this a purification of the principle, it became for every practical purpose a new thing commercially and therapeutically." This foundational (and controversial) precedent affects virtually all pharmaceutical and biotechnology patents to the present day, primarily because "Takamine's product was patentable as an isolated and purified substance only because purification delivered a transformative difference in utility between the new product and its natural precursor" (74); in other words, the new material was substantially more useful than the natural product, hence it was patentable.

Many early investigators used the name "adrenaline", as used by Takamine, but this term was copyrighted as a trademark of Parke-Davis, so that "epinephrine" was eventually adopted as the official generic name, with substantial acrimony. Much of the early disagreement among Abel, von Fürth, and Takamine derived from the fact, learned only later, that Uenaka's crystals of "adrenalin" were contaminated with norepinephrine. In 1906, Ernst Josef Friedmann, who had worked with von Fürth, published the correct chemical structure of epinephrine (75). Hans Meyer and Otto Loewi synthesized "adrenalin" in 1905 but found the pressor effect of the synthetic material to be less than that of the natural product (76); this resulted from the synthesis yielding a racemic mixture of d- and l- optical isomers, whereas the active hormone is only l-epinephrine (77). The epinephrine biosynthetic pathway was proposed by Hermann Blaschko in 1939 (78) and confirmed by others. Epinephrine was distinguished from norepinephrine in the 1940s; the original Takamine "adrenaline" contained about 36% norepinephrine (79).

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Finding Steroid Hormones: Early Studies of Adrenal Physiology

Takamine believed he had identified *the* active principle of the suprarenal gland, and many other early-20th-century investigators also thought the adrenal secreted a single hormone, confounding physiologic work examining the effects of adrenalectomy. In describing the "fight-or-flight" response, Walter Cannon emphasized the sympathetic nervous system and catecholamines but apparently was unaware that adrenocortical hormones also participated (80). Carl and Gerty Cori received a Nobel Prize for describing glycogenolysis (the Cori cycle), which is driven by medullary catecholamines, and noted that adrenalectomy decreased hepatic glycogen (81), but they did not appreciate the role of adrenocortical steroids on carbohydrate metabolism. Glynn had distinguished the functions of the medulla from those of the cortex in 1912 (49), but confusion persisted. Baumann and Kurland may have been first to provide clear evidence for a mineralocorticoid effect by documenting that adrenalectomy (in cats) resulted in hyponatremia and hyperkalemia (82). Rogoff and Stewart showed that adrenalectomized dogs could be kept alive with adrenal cortical extracts (83, 84).

Early efforts to isolate biologically active hormonal substances using extraction procedures with water, saline, or alcohol had been successful with epinephrine (69, 71), thyroxine (85), insulin (86-88) and parathyroid hormone (89) but, as shown by the failure of Brown-Sequard's testicular extract, had failed with steroids. Frank A. Hartman et al at the University of Buffalo used mild acetic acid and "salting-out" with NaCl to prepare an extract from bovine adrenals that modestly prolonged the life of adrenalectomized cats (90). They concluded: "The hormone of the adrenal cortex has been salted out with NaCl. *Cortin* is proposed as the name for this substance. Completely adrenalectomized cats injected twice daily with this substance have survived an average of 27.4 days or longer as compared with 5 to 6 days for controls" (90). Philip E. Smith then devised a rat pharyngeal hypophysectomy procedure that spared the pars tuberalis and hypothalamus: the animals stopped growing; the liver, spleen, and kidneys shrunk; prepubertal animals remained prepubertal; and the adrenals, thyroid, and gonads atrophied (91, 92). Smith's work provided definitive evidence connecting the pituitary to the adrenal and provided important evidence for the role of the hypothalamus (93). In 1930, Swingle and Pfiffner at Princeton (94) and Hartman and Brownell at Buffalo (95, 96) published preliminary reports of the use of lipoidal extraction procedures to prepare adrenocortical material that could sustain the life of adrenalectomized animals and relieve the symptoms of Addison disease; the Swingle-Pfiffner preparation was the first to be used to save an adrenally insufficient, moribund patient at the Mayo Clinic (97). Swingle and Pfiffner improved their preparation somewhat (98, 99), and this preparation was then manufactured and distributed by Parke-Davis under the brand name Eschatin. A few papers describe successful treatment of Addison disease (100) and possible CAH (101) with this preparation, but it was of unclear composition and low potency in vivo (102) and in vitro (103).

Noting that "the sodium content of the blood of patients suffering from Addison's disease is decreased, as it is in adrenalectomized cats," Robert F. Loeb at Columbia University showed that oral administration of saline alone extended the life of a patient with Addison's disease (104), but the basis of this effect remained unclear until aldosterone was isolated 20 years later. George Harrop at Johns Hopkins Hospital similarly noted high potassium and low sodium in animals and patients with adrenal insufficiency. At the Mayo Clinic, patients with Addison's disease were given a high-sodium, low-potassium diet; some patients were stabilized for months on this diet.

Harvey Cushing (105) described pituitary tumors associated with what we now call Cushing syndrome and noted that many of the clinical features observed resembled those seen in patients with adrenal tumors, and some of the autopsy reports mentioned adrenal enlargement, but the pituitary-adrenal linkage was unclear. His concluding paragraph clearly centers on the pituitary: "While there is every reason to concede, therefore, that a disorder of somewhat similar aspect may occur in association with pineal, with gonadal, or with adrenal tumors, the fact that the peculiar polyglandular syndrome, which pains have been taken herein conservatively to describe, may accompany a basophil adenoma in the absence of any apparent alteration in the adrenal cortex other than a possible secondary hyperplasia, will give pathologists reason in the future more carefully to scrutinize the anterior-pituitary for lesions of similar composition." It was apparent that the pituitary did not control all adrenal function, because adrenalectomy killed animals more rapidly than hypophysectomy (106), but our contemporary understanding of the hypothalamic-pituitary-adrenal axis developed much later [reviewed in (107)]. Menkin observed an anti-inflammatory effect of adrenal extracts in 1940 but thought this reflected a reduction in capillary permeability (108). In Montreal, Hans Selye reported that rats receiving "nocuous agents" (exposure to cold, surgery, spinal transection, sublethal doses of drugs or formalin) exhibited a 3-phase stress response that included adrenal hyperplasia and involution of the thymus—the discovery of glucocorticoid action (109). He integrated these and other findings into the conceptualization of the hypothalamic-pituitary-adrenal axis, defined what we now know as "the stress response," coined the terms "mineralocorticoid" and "glucocorticoid," and emphasized that both classes of steroids were needed for survival (110). Thus, chemical identification of adrenocortical factor(s) was needed.

Finding Steroid Hormones: Early Studies of Adrenal Steroid Chemistry

Heinrich Otto Wieland and Adolf Otto Heinrich Windaus will always be remembered together. These German chemists were personal friends and colleagues and won sequential Nobel Prizes in Chemistry in 1927 and 1928 (both awarded in 1928) for work with sterols (111, 112). Both also openly resisted the Nazi regime and refused to sign the Nazi loyalty oath in 1933 ["Bekenntnis der Professoren an den Universitäten und Hochschulen zu Adolf Hitler und dem nationalsozialistischen Staat" (the "Vow of allegiance of the Professors of the German Universities and High-Schools to Adolf Hitler and the National Socialistic State")] but were shielded from Nazi persecution by their status as Nobel laureates (113). Wieland was a professor in Munich and in Freiburg who received the Nobel "for his investigations of the constitution of the bile acids and related substances" (111). Windaus, a professor in Göttingen, received his Nobel "for

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the services rendered through his research into the constitution of the sterols and their connection with the vitamins" (specifically, vitamin D) (112). Illustrating the difficulty of determining complex chemical structures with the tools available in the 1920s, Wieland and Windaus published structures for cholesterol, but both got it wrong (Fig. 9). Rosenheim and King reported the correct structure in 1932 (114).

In 1933, Carl von Ossietzky, the German author, pacifist, and publisher of the political journal *The World Stage* was arrested by the Nazis and imprisoned at Esterwegen prison and then at the Sonnenburg concentration camp (where he died of tuberculosis in 1938) for documenting German rearmament in violation of the Treaty of Versailles, beginning during the Weimar Republic (115). In response, Hitler ordered all Nazis to refuse Nobel Prizes, much to the dismay of many scientists who viewed themselves as candidates (and had signed the Nazi loyalty oath). In 1939, Windaus's former student Adolf Freidrich Johann Butenandt (Nazi Party member #3716562) and Leopold Ruzika (a Swiss/Croatian) were awarded the Nobel Prize in Chemistry for isolating estrone, androstenedione, and progesterone. Butenandt apparently lacked his former mentor's ethics. On orders from the Reich, Butenandt declined the prize and instead was given the infamous "War Merit Cross" by Hitler in 1942 (among the approximately 100 other Nazis so recognized were Adolf Eichmann, Josef Mengele, and Albert Speer). Ruzika delivered his Nobel lecture in 1945, after World War II (116). Butenandt appealed to the Nobel Committee and was officially listed as a Nobel laureate in 1949 and received the diploma and medal but no prize money, and he did not deliver a Nobel lecture. Butenandt directed the Kaiser Wilhelm Institute for Biochemistry from 1937 to 1945, directing biochemical research for Germany's war effort (115). After the war, Butenandt returned to science and attempted to rehabilitate his reputation: with Karlson he isolated and determined the structure of the insect steroid hormone ecdysone (117).

Major advances in steroid chemistry were made by Tadeus Reichstein, whose family escaped the pogroms in Russian-occupied Poland and eventually settled in Switzerland. Reichstein became a Swiss citizen and received his doctorate from the Swiss Federal Institute of Technology (ETH) in Zürich in 1922, working under Hermann Staudinger (1953 Nobel Prize in Chemistry) and later under Leopold Ruzicka (1939 Nobel Prize in Chemistry) (Figs. 10, 11). Much of Reichstein's biography has been recorded by Miriam Rothschild, with whom he later isolated insect cardioglycosides (118). Working with his lifelong assistant Joseph von Euw, Reichstein first achieved prominence in organic chemistry by isolating aromatic components of coffee in 1931 (119) and then by devising what is now known as "the Reichstein Process" for synthesizing vitamin C (first isolated in 1928 by Albert Szent-Gyorgyi) (114, 120). His work with steroid hormones at ETH was well underway (121, 122) supported by the Dutch pharmaceutical company NV Organon, but Ruzicka, the director at ETH, had a contract with CIBA that required that patent rights concerning steroid research had to be assigned to CIBA; Reichstein's contract with Organon excluded this, so Reichstein left in 1938 to become chair of the Department of Pharmaceutical Chemistry in Basel. From 1938 to 1950, Reichstein published hundreds of papers describing the isolation, chemical characterization, and synthesis of over 2 dozen steroids (123). Prior work to identify, purify, and isolate hormones, such as epinephrine, thyroxine, insulin, and parathyroid hormone, had been facilitated by their abundant intracellular storage, but this is not the case for steroids. Steroidogenic cells do not produce steroids and store them for later release; the rate of steroid release is determined by steroid synthesis so that the amount of steroid in an adrenal cortex is surprisingly low (as described later, this ultimately led to the discovery of the steroidogenic acute regulatory protein in the 1990s). Starting with ~500 kg adrenals from 10 000 cattle (provided by NV Organon, whose main business was extracting bovine insulin), Reichstein isolated and determined the structures of 28 adrenal "corticoids," only 5 of which had biological activity. In 1953, 3 years after winning the Nobel, in collaboration with Sylvia Simpson and James Tait, he isolated aldosterone (124, 125).

The preparation of "cortin" by Swingle and Pfiffner (94, 98, 99) spurred great interest in adrenal steroids in the United States. Most notably and contemporaneously with Reichstein, Edward C. Kendall at Mayo Clinic was trying to isolate adrenal steroids in the 1930s. Kendall was an established figure: he had purified thyroxine in 1915 (127) and had isolated glutathione and determined its structure (128), but his attempts to determine thyroxine's structure failed. Harington and Barger at University College London

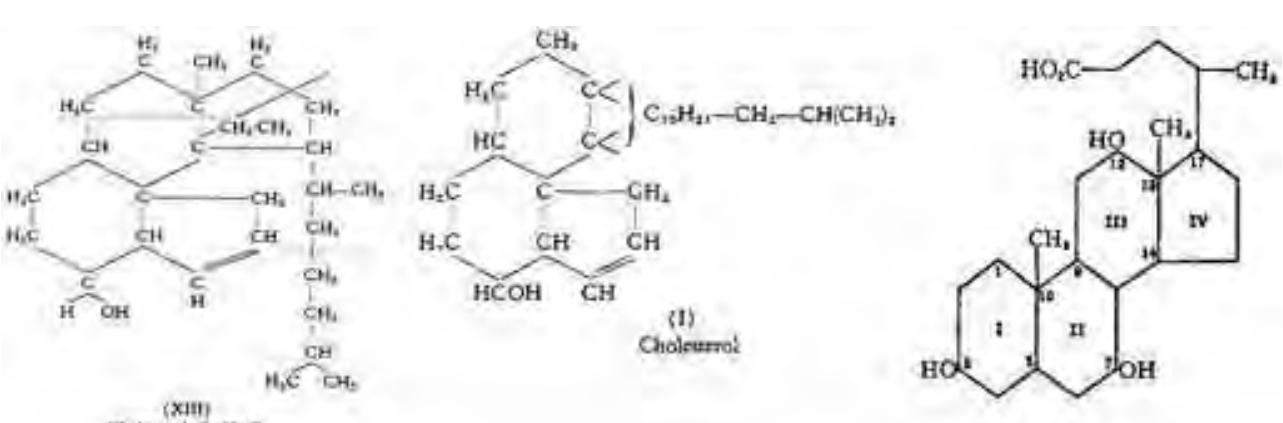

Figure 9. Structures proposed for cholesterol. *Left,* structure according to Heinrich Wieland (111) (in the public domain at https://www.nobelprize.org/uploads/2018/06/wieland-lecture.pdf). *Center,* structure as proposed by Adolf Windaus (112) (in the public domain at https://www.nobelprize.org/uploads/2018/06/windaus-lecture.pdf). *Right,* structure as proposed by Rosenheim and King (114).

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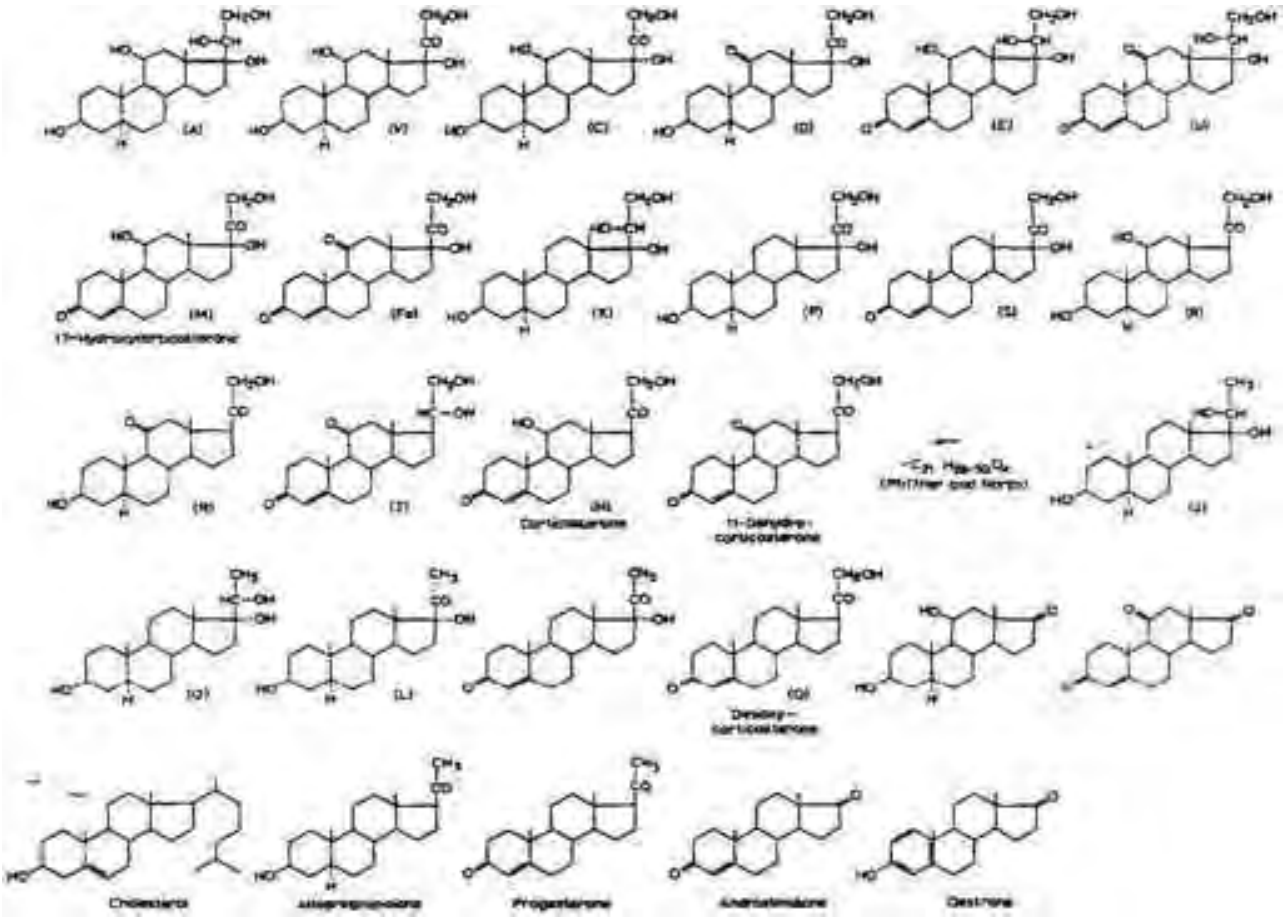

Figure 10. Structures of the 28 steroids that were chemically characterized by Reichstein between 1938 and 1949 (123) (in the public domain at https://www.nobelprize.org/uploads/2018/06/reichstein-lecture.pdf).

Figure 11. *Left,* Tadeus Reichstein (1897-1996) as a well-dressed graduate student at the Swiss Federal Institute of Technology in Zürich, 1923. From (118); reproduced courtesy of Schweitzerische Stiftung für die Photographie. *Right,* The Kendall lab, 1948, with the principal investigators of the use of cortisone for rheumatoid arthritis. Left to right: Charles H. Slocumb, Howard F. Polley, Edward C. Kendall, and Philip S. Hench [from (126), reprinted with permission].

published the correct structure in 1927 (129). In 1929, Albert Szent-Gyogyi, who had isolated vitamin C, was a visiting professor at Mayo for 8 months, where he prepared vitamin C from bovine adrenals. It was at this time that the Swingle-Pfiffner adrenocortical extract ("Eschatin") had been used by Leonard G. Rowntree, chair of medicine at Mayo, to help save an adrenally insufficient, moribund patient (97). As related by Ingle in his obituary for Kendall for the National Academy of Sciences (130), Rowntree then urged Kendall to pursue the preparation of adrenal extracts, rather than just making cortin, Kendall decided to pursue the isolation of its active principle. Kendall made an arrangement with

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Parke-Davis to receive about 900 pounds of bovine adrenal glands each week, Kendall would separate crude epinephrine for Parke-Davis and retain the "left-over" cortical material to prepare the cortin that was used to treat Mayo's Addisonian patients who had failed treatment with their high-sodium, low-potassium diet; this was also the starting material for his efforts to purify *the* cortical hormone. Like others in the field, Kendall initially thought there was only 1 adrenocortical hormone. Many adrenal steroids will cocrystalize and appear to represent a single compound, but the work of Reichstein in the 1930s showed this was not the case; by about 1934, most investigators acknowledged that the adrenal secreted multiple biologically active steroids. By 1935, 4 groups were trying to isolate adrenal compounds: Kendall at the Mayo Clinic, JJ Pfiffner who had moved from Princeton to join Oskar Wintersteiner at Columbia University (131), Cartland and Kuizenga working at Upjohn, Inc. (132), and Reichstein in Zurich. By then it was known that adrenocortical secretions influenced carbohydrate metabolism, virilization, and salt and water balance; it was logical to presume that different steroids exerted different effects, but only small amounts of the individual steroids could be prepared, and the animal bioassays then available were insufficiently sensitive. Although there was rivalry among the groups, they also shared samples and information. Reichstein and Wintersteiner were superior chemists, but they lacked assays for biological activity.

In 1934, Dwight J. Ingle (president of the Endocrine Society, 1959-1960) finished his doctorate (in psychology) at the University of Minnesota after joining Kendall's lab in 1932. Ingle had developed an assay to measure muscular work in anesthetized rats: a 100-g weight was affixed to the gastrocnemius muscle and was stimulated electrically to lift the weight 3 times per second. Normal rats could do this for >14 days, but the work capacity of an adrenalectomized rat fell below that of sham-operated controls within 2 hours, and muscular responsiveness was lost within a day (133). Ingle developed a modified 24-h assay of adrenal cortical extract that was sensitive, fast, and reliable. Replacement with epinephrine was of no avail, but Kendall's cortical extract permitted nearly complete recovery, in a dose-response fashion: there was now a viable laboratory bioassay for glucocorticoid action (134). Although Kendall's first crystalline adrenocortical preparation (announced with much fanfare in 1934) (135) was inactive, they were on track. Kendall's "compound E" (later identified as cortisone) was active in the muscle work test in late 1935 (136); Wintersteiner and Pfiffner (131) and Reichstein (122) had also isolated compound E but were unaware of its biological activity. Kendall then converted compound E to a diketone, and Fred Conrad Koch demonstrated this derivative had androgenic activity that "was one-sixth to one-fourth as active as androsterone in stimulating comb-growth in the capon" (136). Thus, independently and by different tactics, the different groups now knew that compound E was a steroid. Ingle left Mayo for the University of Pennsylvania, where he used his assay to measure and compare the work capacity of multiple, structurally characterized steroids (137).

Steiger and Reichstein prepared 11-desoxy-corticosterone (DOC) in 1937 (138), and several groups showed it could sustain the life of adrenalectomized animals or patients with Addison's disease (139-142). Kendall's other compounds, termed "A," "B," "E," and "F," were 11-oxygenated; Hans Selye called the 11-hydroxy steroids "glucocorticoids" and the 11-deoxy steroids "mineralocorticoids" (110); like many oversimplifications, this one contained a nub of truth. Kendall's operational alphabetical names were applied before the structures were known; "A" was 11-dehydrocorticosterone, "B" was corticosterone, "E" was 17-hydroxy-11-dehydrocorticosterone (cortisone), and "F" was 17-hydroxy corticosterone (cortisol). Wintersteiner and Pfiffner found that noncrystalline adrenocortical extracts were much more potent than Kendall's compound E in sustaining the life of adrenalectomized animals (131), and only miniscule amounts of DOC were found in adrenal extracts, suggesting that DOC was not *the* life-maintaining (salt-retaining) adrenocortical hormone. Much of that activity remained in what Kendall called "the amorphous fraction," which was later shown to contain aldosterone (124, 125).

With the synthesis of DOC, much of the fire went out of the competition to isolate a clinically important adrenocortical hormone; many major players, including Pfiffner and Wintersteiner and Cartland and Kuizenga, left the field. Kendall remained committed. World War II essentially ended expensive animal experimentation but also stimulated adrenal research. It was rumored that Germany was procuring beef adrenals in Argentina and preparing an adrenocortical extract that permitted Luftwaffe pilots to fly to higher altitudes (130). The rumors about Argentine adrenals were false, but the US military considered that adrenocortical extracts might be useful in treating traumatic shock and surgical shock and might improve soldiers' responses to stressors. The medical research division of the Office of Scientific Research and Development gave high priority to the synthesis of Kendall's compound A as a precursor to making the more active compound F (cortisol). Several pharmaceutical groups were involved, and communications with Reichstein were maintained; by the end of the war, Merck and Co. had prepared ~100 g of compound A, but animal studies failed to show utility in hypoxia or surgical or traumatic shock, and clinical studies showed little value in Addison's disease. Most of the chemists involved quit the project (130). Nevertheless, Kendall convinced Merck to continue work toward compound E, and, by 1948, they had prepared ~9 g of compound E; by this time Merck had invested over $14 million on the project. With no proven medical use, Merck was ready to "pull the plug" on compound E.

Philip Showalter Hench was the Mayo Clinic's first rheumatologist; he had been recruited by Leonard G. Rountree and was appointed head of the new Division of Rheumatology in 1926 at age 30. In 1929 he began to take interest in how the symptoms and clinical courses of arthritis differed in patients who also had other conditions. Hench was a brilliant clinical observer who could see patterns in disease that others had not. He first reported symptomatic improvement in 16 patients with chronic rheumatoid arthritis who also had hepatitis with jaundice (most caused by the hepatotoxicity of the analgesic drug cinchophen) (143). In 1938, he reported 31 more cases; he noted that the degree of symptomatic remission correlated with the degree of jaundice rather than with the cause of the liver disease and that administering bile or bile salts did not reproduce the analgesic effect (144). He also noted that arthritis and allergies improved in pregnant patients and that the benefits persisted long after parturition or the remission of the liver disease, suggesting that the salutary effects were not mediated by metabolites of bilirubin. Hench

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was a student of medical history, noting dozens of earlier reports about spontaneous temporary remission of arthritis associated with hepatic injury or pregnancy, but none of the earlier reports pursued the observation, considered similarities and differences among the reports, or tried systematic interventions (145). He postulated that the effects were due to an unknown, endogenous "substance x" that was made in both men and women (144).

Kendall and Hench began collaborating in about 1938; in 1941 they agreed to try compound E for arthritis when sufficient material became available. They tried "cortin" in 3 patients, with negative results (146). Hench's military service in World War II and the high cost and difficult preparation of compound E delayed the planned trial. In September of 1948, compound E became available from Merck and was injected into a severely affected arthritic patient, yielding a dramatic improvement. The clinical study was expanded; almost all arthritic patients so treated went into a remission that lasted so long as the treatment was continued. Intramuscular adrenocorticotropic hormone (ACTH) yielded similar results. This produced great excitement at Mayo, but caution initially prevailed, and the results remained confidential for several months. There were concerns that the doses used to suppress the symptoms of arthritis were large, and it was suspected that prolonged high-dose treatment would cause Cushing's syndrome, cause adrenal atrophy, or inhibit the pituitary's ability to control adrenal secretions normally (147). Nevertheless, the results became known to the press, and great excitement ensued about a "cure" for arthritis. Hench, Kendall, and their collaborators (Fig. 11) described their basic work and clinical results in great detail, cautioning that compound E was experimental, that it was not a cure, and that overdose effects were likely (146), but the press and the public didn't understand or care. A movie clip of a wheelchair-bound arthritic patient arising and walking after 3 days of intramuscular cortisone (100 mg/d) was seen widely, and there was tremendous pressure on the Mayo Clinic and Merck to provide compound E. Kendall, Reichstein, and Hench equally shared the 1950 Nobel Prize for Medicine or Physiology (123). In Hench's speech at the Nobel banquet, he acknowledged Kendall and Reichstein by saying "Perhaps the ratio of one physician to two chemists is symbolic, since medicine is so firmly linked to chemistry by a double bond." Many chemists received Nobels for work with sterols (Wieland, Windaus, Butenandt, Ruzika, Kendall, Reichstein), but Hench's unique contributions vaulted steroids from an esoteric branch of organic chemistry to the very center of medicine and pharmacology.

With the advent of the clinical use of cortisone and the identification of the structures of the "alphabet soup" of compounds identified by Reichstein and Kendall, the golden age of steroid chemistry was nearly over. Only 1 major question remained—the nature of the life-sustaining component (sometimes called "electrocortin") that powerfully influenced electrolyte balance, presumably an 11-desoxy-steroid in Kendall's "amorphous fraction" of adrenal extracts. Kendall did not pursue this question, but Reichstein and his colleagues did. Simpson and Tait developed a sensitive bioassay that permitted the crystallization of 21 mg of electrocortin from 500 kg of bovine adrenals (124) and, with the subsequent determination of its structure, the last major biologically active steroid, aldosterone, had been discovered [reviewed in (148)], greatly aided by the new technique of paper chromatography (149).

History of CAH Due to 21-Hydroxylase Deficiency

To most endocrinologists, the term "congenital adrenal hyperplasia" means "steroid 21-hydroxylase deficiency" (21OHD), but in fact there are multiple forms of CAH; these are attributable to mutations in different genes and to variations in severity and clinical phenotypes of mutations within single genes. We consider the history of each form separately. Lipoid CAH is discussed in the section titled "The Role of Corticotrophin (ACTH) in Regulating Adrenal Steroidogenesis."

Clinical Investigation

Understanding of CAH as a distinct entity developed fairly rapidly in the 1930s; several cases were reported, and Marrian and Butler established that the urinary steroid pregnane-3,17,20-triol (pregnanetriol) was elevated in all cases of adrenal virilism (both CAH and virilizing adrenocortical carcinomas) (150-152), while others, notably Russell E. Marker, identified multiple steroids in the urine of pregnant women (153). Marker subsequently achieved fame and fortune by inventing the "Marker Degradation" for preparing progesterone from diosgenin extracted from Mexican *Dioscorea* root, the origins of the oral contraceptive industry (which will not be covered here). Fifteen years later, Bongiovanni et al showed that urinary pregnanetriol was the hepatic metabolite of 17-hydroxyprogesterone (17OHP) (154). However, the early measurements urinary pregnanetriol required huge volumes of urine (>1 week's excretion) and was technically demanding, hence its use as a marker for CAH had to await technical advances.

The 1940s saw the first scientific clinical investigations of CAH, reported by 2 of the founding fathers of pediatric endocrinology, Lawson Wilkins (1894-1963) at Johns Hopkins University and Nathan B. Talbot (1909-1994) at Massachusetts General Hospital. Talbot was 15 years younger than Wilkins, but their research careers with CAH began contemporaneously in the late 1930s. By this time, it was generally understood that the adrenal made several hormones that did different things: DOC acted on electrolyte balance, corticosterone (and later compound E) raised blood sugar via gluconeogenesis, and as-yet-undescribed hormones could result in virilization. Working under Allan M. Butler (chief of the Children's Medical Service and staff physician in charge of the Chemical Laboratories at Massachusetts General Hospital), Talbot co-authored a case report of probable CAH, published in December 1939 (101); that report mentions Wilkins' oral presentation of a similar case, published in March 1940 (155). The case reported by Butler and Talbot was a male infant followed from age 2 weeks to 20 months with skin pigmentation, enlarged genitalia (but small testes), a propensity to "collapse" with associated hyponatremia and hyperkalemia if fluids or salt were withheld, urinary excretion of large amounts of "estrogens and androgens," and successful maintenance with added salt and bicarbonate (101). Treatment with the Parke-Davis "Eschatin" adrenal extract was ineffective, but the addition of 5 g of sodium chloride and a charcoal adsorbate of adrenal cortical extract containing "3 rat units" daily resulted in weight gain without edema and normalization of the serum Na and K, but the adrenal extract without added sodium was ineffective (the "rat units" probably refer to Ingle's muscle-work bioassay, described earlier). The patient could be maintained with parenteral cortical extract from Upjohn "providing 4 rat units daily." A diet

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supplemented with sodium chloride and sodium bicarbonate yielded moderate weight gain and improved levels of sodium and potassium.

Lawson Wilkins had been in the private practice of pediatrics in Baltimore for 14 years before establishing the world's first pediatric endocrine clinic at Johns Hopkins in 1935. Personal biographies of Wilkins have been published by his daughter (156) and by his former trainee and colleague Claude Migeon (157); a summary of his career is contained in Delbert Fisher's history of pediatric endocrinology (158). Wilkins was at the forefront of efforts to link anatomical adrenal hyperplasia with functional adrenal insufficiency and androgen excess. Wilkins encountered a $3^1/_2$-year-old boy with "marked development of his secondary sex organs" who had developmental delay, mental retardation, low serum sodium, and a profound craving for salt, a clinical point he emphasized in his first report of this child (155). Wilkins' more detailed report of this early case of CAH combined astute clinical observation with then-new bioassays of steroids (159). In addition to the salt craving, Wilkins reported polyuria, polydipsia, and a deceased 5-week-old "female pseudohermaphrodite" sibling. His "parents noticed at birth that his penis and scrotum were unusually large"; he developed acne at 5 months, pubic hair at 15 months, and asymmetric testicular enlargement "several months later." He was thin, tall, muscular, generally pigmented (including the gums), and had asymmetric pubertal-sized testes; blood pressure was 90/50 (Fig. 12). Laboratory data showed normal glucose, calcium, and phosphorus; hemoglobin of 16.3 g/100 ml; white count of 19 000; and elevated nonprotein nitrogen. He died unexpectedly on day 6 of hospitalization. "Immediately after his death blood was taken by cardiac puncture for chemical studies, which showed serum sodium 111 m.eq. per liter." Autopsy showed grossly enlarged adrenals (total weight 27 g) with "accumulation of large cells" "characteristic of the androgenic type." The testes contained masses containing cells "similar to those described in the adrenals" but without Leydig cells (ie, probable testicular adrenal rest tumors). A castrate rat bioassay for urinary androgens showed 30 IU per day, the same as that of a normal adult man. Alcohol extracts of 6.3 g of testicular tissue yielded 5 IU of androgen, whereas 31 g of normal adult testicular tissue yielded no detectable androgen. Using the cock's comb bioassay for androgens initially described in 1849 by Arnold Berthold (160), an extract of 3.5 g of adrenal tissue "failed to show measurable androgen," but extract from 2 g of adrenal tissue "caused growth when rubbed into the comb of a 11-day-old-chick over a period of 7 days." Wilkins' discussion proposes that "female pseudohermaphrodites" have hyperplasia of the "prenatal zone" of the adrenal and that virilizing tumors contained the same tissue, indicating that this "androgenic zone" is distinguished from "the electrolyte-controlling portions of the cortex, the 'interrenal cells.'"

A friendly rivalry arose between Boston and Baltimore. Boston had all the advantages—a larger clinical base, outstanding biochemistry, and the world's best endocrinologist: Fuller Albright. Talbot described 12 additional patients with CAH, focusing on 17-ketosteroid (17KS) excretion and contrasting them with patients with virilizing adrenocortical carcinomas (161). Talbot's 1943 paper about a patient with Addison's disease (probably due to autoimmune polyglandular syndrome type 1) also reported increases in urinary 17KS in CAH and showed that unilateral adrenalectomy was not valuable in CAH (162). Albright distinguished adrenogenital syndrome (CAH) from Cushing

Figure 12. Patient with congenital adrenal hyperplasia reported by Wilkins et al (159), with scrotal enlargement suggesting the presence of testicular adrenal rest tumors.

syndrome in 1943 (163). Debate concerning the roles of the pituitary and adrenal in Cushing syndrome persisted (164) until about 1950, when Bauer concluded that both the pituitary and the adrenal can separately cause "the so-called Cushing's syndrome" and that the term "Cushing's disease" be reserved for the pituitary form (165).

Talbot's principal interests were in practical steroid chemistry: he worked with George Langstroth at MIT to devise apparatus for determining urinary androgens in clinical laboratories (166) and refined existing colorimetric assays for 17KS (161, 167, 168) and corticoids (168). However, Talbot's 1950 paper describing the long-term follow-up of the patient he had described with Butler et al in 1939 added no new clinical, physiological, or chemical insights (169). And despite their shared institutional affiliation and interests, Talbot and Albright collaborated only once, correlating urinary "11-oxocorticosteroid-like substances" (17-hydroxycorticosteroids) and the apparent activity of what they called the "S-hormone" (designating the "sugar-active" adrenal hormone(s), cortisol) (170). Fuller Albright only became involved in CAH in 1950.

In 1949, Zuelzer and Blum proposed that "the combination of cortical insufficiency, masculinization, and diffuse adrenal hyperplasia forms a distinct anatomic-physiologic entity" (171). Their literature survey found 9 papers published from 1937 to 1945 reporting 17 cases, including those reported by Wilkins (155) and by Butler (101) cited earlier. They

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presumed the disorder to be fairly common as they found 4 cases among 1068 autopsies of children 0 to 13 years old, with most cases in infancy. The genital virilization in the females was typical of the congenital form of the adrenogenital syndrome "in which excessive production of androgens by the fetal adrenals is thought to inhibit differentiation of female structures and to stimulate growth of the sex organs along male lines of development."

The state of understanding of adrenal pathophysiology just before CAH was first treated with cortisone is vividly shown by the presentations by Talbot and by Wilkins at the 1949 meeting of the American Academy of Pediatrics and the following question and answer dialogue (172). Talbot reviewed steroid structure-function relationships and their physiologic actions. He described DOC as the principal "Na-K hormone," 11-oxo-corticosteroids as the "sugar-fat-nitrogen" hormone(s) active in carbohydrate metabolism, and an "androgenic, or protein anabolic 'N' hormone" that is metabolized to 17KS. He speculated about their importance in normal physiology but did not address disease states. Wilkins discussed (i) "adrenogenital syndromes," distinguishing congenital (CAH) from "postnatal" (adrenal tumors), and (ii) "Cushing's syndrome," which he described as of hypothalamic, pituitary, or primary adrenal origin, and correctly listed the apparent steroidal abnormalities in each. His description of the anatomy of girls with CAH is quite contemporary; he erred in saying that CAH is more common in girls than boys but correctly suggested that boys may be under-ascertained because of infant death and lack of distinct early anatomic findings. Notably, he distinguished CAH from precocious puberty based on testicular enlargement (an important point of the physical exam that many physicians still overlook today). He illustrated infants treated successfully with DOC or "adrenal cortical extract" and discussed the differential diagnosis of the various forms of hyperandrogenism. This paper is remarkable in showing Wilkins' early understanding of adrenarche, presumed adrenal insufficiency in infants, and the proper management of "pseudohermaphroditism" in CAH, issues that remain under investigation today. At about the same time he showed that adrenalectomy had salutary effects in CAH but that its efficacy was severely limited by then-inadequate adrenal replacement therapy (173).

The isolation and synthesis of cortisone and its success in treating Addison's disease and arthritis quickly suggested use in CAH. Wilkins saw the potential of Kendall's compound E, but Talbot had become involved in nonsteroidal areas of endocrinology and was not involved in the revolutionary treatment of CAH with cortisone. By 1949, Wilkins was clearly the leading authority on CAH, but the Boston-Baltimore rivalry remained, as Fuller Albright and his fellow Frederic C. Bartter at Massachusetts General Hospital entered this academic contest. Fuller Albright had an unmatched career of clinical and basic endocrine investigation in the 1930s and 1940s, mostly in bone metabolism, but his progressive Parkinson's disease impaired him severely in the 1940s. Wilkins and others had successfully treated salt loss with deoxycorticosterone but failed in treating CAH with ACTH or testosterone (174). Wilkins then published a brief "Preliminary Report" in the *Bulletin of the Johns Hopkins Hospital* describing suppression of urinary 17KS in 1 CAH patient treated with 100 mg cortisone daily (175); the paper was received on Feb 13, 1950, and published in April; the *Bulletin* did not use external review. Wilkins begins: "Unsuccessful attempts have been made by us (unpublished) to suppress the secretion of 17-ketosteroids in patients with this disorder by the administration of steroids, such as 17-ethyl testosterone, 17-vinyl testosterone, 17-methyl androstenediol and 17-methyl androstanediol, which have a chemical structure similar to that of androgens but possess relatively little androgenic activity" and concludes that cortisone "suppressed the secretion of adrenal hormones responsible for the urinary excretion of 17KS" (175). Wilkins did not mention the pituitary or ACTH. At the same time, Bartter presented an abstract on May 1, 1950, at the annual meeting of the American Society for Clinical Investigation describing his and Albright's unsuccessful treatment of CAH with ACTH but successful treatment with cortisone. They concluded: "These findings suggest that the adrenogenital syndrome results, not from an abnormal pituitary stimulation of the adrenal, but from an abnormal adrenal response to a normal pituitary" (176). Both groups followed their preliminary reports with full papers. Wilkins' paper was received for publication on Nov 21, 1950, and was published in Jan 1951 (177); Bartter's paper was received on Nov 2, 1950, and was published in Feb 1951 (178). Each group cited the other's preliminary report. Wilkins began by describing unsuccessful treatments with steroids "which have a chemical structure similar to that of androgens but possess relatively little androgenic activity" before trying cortisone. Wilkins correctly concluded: "We suggest that the action of cortisone is to suppress the output of pituitary adrenocorticotropin, thereby causing marked diminution of the secretion of the pathologic adrenals" (177). Bartter and Albright approached the problem by considering the similarities and differences between CAH and Cushing's syndrome and concluded with a diagram of the correct physiology (Fig. 13) (178). Thus Wilkins and Bartter/Albright deserve equal credit for proposing the treatment of CAH with cortisone. Following the reports of successful treatment of CAH with cortisone, Wilkins exerted tremendous effort to optimize its use and investigate the effects of cortisone on sexual development, growth, electrolyte metabolism, hypertension, and testicular development (179-183). These detailed metabolic balance studies established the therapeutic approach to CAH that largely remains in effect today (184, 185). Talbot also made important further contributions, showing that both cortisone (186) and diethyl stilbesterol (187) could cause growth arrest. Albright was rendered vegetative by unsuccessful chemopallidectomy for his Parkinson's in 1956, and Bartter went on to describe syndrome of inappropriate antidiuretic hormone ADH release but did not follow up on the work with CAH.

What Is Disordered in CAH?

Both Wilkins and Bartter/Albright assessed responses of patients with CAH to treatment with cortisone by measuring urinary 17KS, but they did not know they were dealing with steroid 21OHD. Before the biochemical lesion could be identified, a general knowledge of the adrenal steroidogenic pathways was needed. The 30 steroids identified by Reichstein and others could, hypothetically, be arranged into several different potential steroidogenic pathways. Oscar Hechter and Gregory Pincus at the Worcester Foundation for Experimental Biology in Shrewsbury, Massachusetts, devised the novel procedure of isolating bovine adrenals with their arteries and veins intact,

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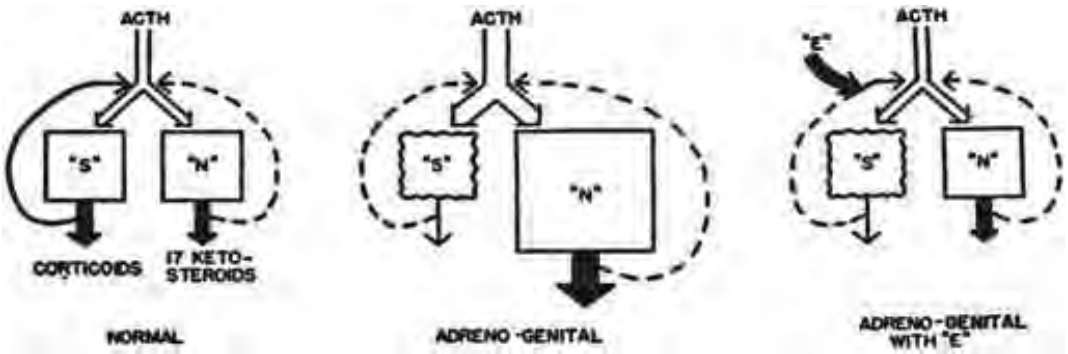

Figure 13. The physiology of congenital adrenal hyperplasia, described by Bartter et al in 1951 (178) (in the public domain at https://www.jci.org/articles/view/102438/pdf). In these diagrams, "S" does not refer to Reichstein's compound S (11-deoxycortisol) but to the then-unknown steroid active in sugar metabolism (now known to be cortisol); "N" refers to the then-unknown adrenal androgen that influences nitrogen retention (now known to be 11-keto-testosterone). In the right-hand panel, "E" refers to Kendall's compound E (cortisone).

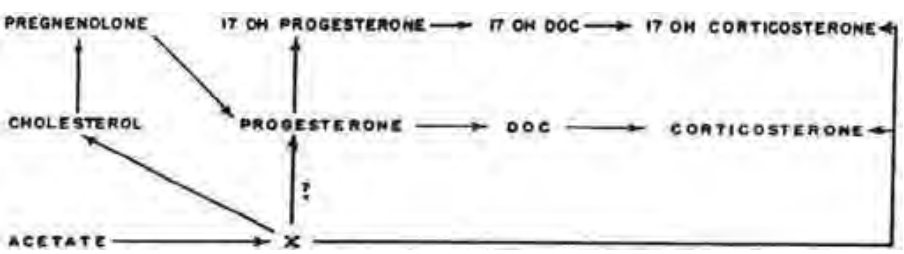

Figure 14. The first steroidogenic pathway, as proposed by Hechter and Pincus in 1954 (193); reprinted with permission. The pathway is largely correct, as acetate is converted to cholesterol through a complex, 30-step pathway, represented by "x." However, none of the intermediates in that pathway is converted to progesterone or other steroids without first being converted to cholesterol.

then infusing a potential precursor into the adrenal artery and measuring the steroids in the venous effluent (188, 189). With the new availability of radiolabeled steroids, the specificity of the conversions was assured (190). When adrenals were perfused with ^{14}C-labeled acetate, cholesterol, or progesterone, ACTH stimulated incorporation of ^{14}C into steroid products only when cholesterol was the precursor; ACTH had no effect on conversion of acetate to cholesterol (191). This study established that ACTH acts on the conversion of cholesterol to progesterone. However, their data with ^{14}C-acetate suggested the existence of steroidogenic pathways that do not involve cholesterol; later studies showed that this is not the case. With this powerful new technique, Hechter and Pincus proposed the first steroidogenic pathways (192, 193) (Fig. 14). These and other studies were often inconsistent and difficult to apply to measurements from human patients, as early investigators did not anticipate the significant differences in the enzymes and pathways of steroidogenesis among various mammals, especially human beings.

Alfred M. Bongiovanni (1921-1986) trained in steroid chemistry with William Eisenmenger at Rockefeller (194, 195) and clinically with Wilkins at Hopkins, where he became an assistant professor and worked independently, establishing the steroid assay lab at Johns Hopkins (196, 197). In 1955 he showed that different patients with CAH had different steroidogenic lesions: most accumulated pregnanetriol in their urine, indicating an inability to convert 17OHP to compound F(ie, 21OHD), but 1 patient had hypertension and "large quantities of Reichstein's compound S (11-deoxycortisol) and its metabolites" in blood and urine. This was the first steroidal evidence for a variant form of CAH [11-hydroxylase deficiency (11OHD)] and permitted the drawing of the first truly modern steroidogenic pathway (Fig. 15) (198, 199). In a footnote he adds, correctly, "The hypertension described as a complication of the adrenogenital syndrome may be due to the secretion of desoxycorticosterone." Bongiovanni followed up on this work with even more sophisticated steroidal analyses showing that (i) CAH is due to a lack of "21-hydroxylase," (ii) that normal and 21OHD adrenals have an "11-hydroxylase," and (iii) 21-hydroxylation precedes 11-hydroxylation in the human adrenal (200).

Although Bongiovanni had distinguished CAH caused by 21OHD from CAH caused by 11OHD in 1955 (see "11OHD") (198), this was not immediately accepted. In a study with Joseph Jailer, the prominent steroid chemist Seymour Lieberman (1916-2012; president of the Endocrine Society 1974-1975) concluded: "The evidence accumulated to date does not appear to indicate that congenital adrenal hyperplasia is characterized by a single enzymatic block" (201). Definitive evidence for a defect in 21-hydroxylation in most patients with CAH came from 2 groups in 1957. Fukushima and Gallagher concluded: "Thus this patient exhibited a serious deficiency of 21-hydroxylation with an excessive amount both of steroids intermediate in hydrocortisone production and 'adrenal androgens,' defined by the metabolites androsterone and etiocholanolone" (202). Similarly, Bongiovanni and Elder found that "These data thus confirm earlier indirect work pointing to a lack of '21-hydroxylase' and the presence of '11-hydroxylase' in the adrenal glands of patients with the normotensive form of this disorder. The results also suggest that 21-hydroxylation occurs prior to 11-hydroxylation in man" (200). The "block" at 21-hydroxylation was reconfirmed by other work (200, 203). Whether 21-hydroxylation precedes or follows 11-hydroxylation was unclear; if 21-hydroxylation occurred first, 17OHP would accumulate in 21OHD, but if 11-hydroxylatione occurred first, 21-deoxycortisol would

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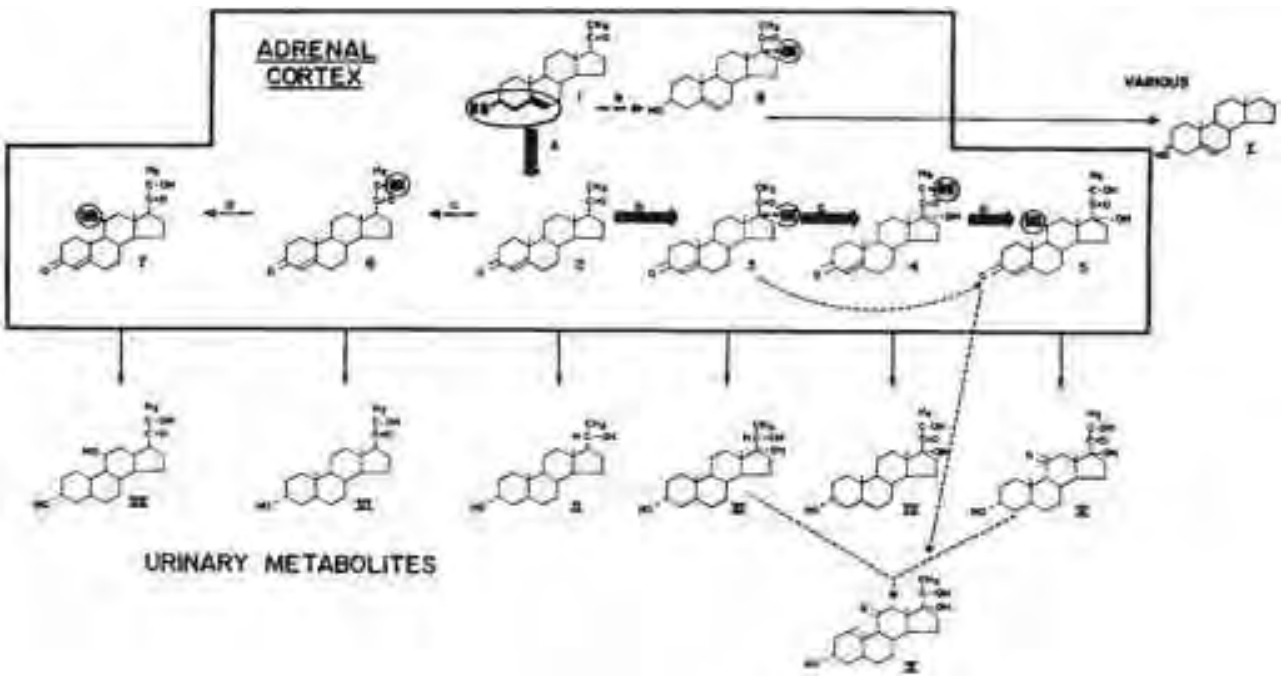

Figure 15. Bongiovanni's steroidogenic pathway from 1963 (199). Cortisol is (5) and corticosterone is (7). The various enzymes, A (3β-hydroxysteroid dehydrogenase), B (17-hydroxylase), C (21-hydroxylase), and D (11-hydroxylase) are illustrated, and their sites of action are shown by the encircled heavy type. The most common form of congenital adrenal hyperplasia is characterized by a lack of 21-hydroxylase (C) and hence an accumulation of 17-hydroxyprogesterone (3) with the excretion of large quantities of the latter's reduced metabolite, pregnanetriol (III) (reprinted with permission; ©1963 Massachusetts Medical Society. All rights reserved).

accumulate. Actually, both pathways are active. Jailer was the first to report that both 21-deoxycortisol and 17OHP were elevated in CAH (204), and he studied the roles of both steroids in CAH, but he focused on 17OHP because it was thought to be an androgenic steroid (201). Thus the lack of apparent hormonal activity for 21-deoxycortisol, and the close correlations among urinary 17KS, urinary pregnanetriol, and serum 17OHP, resulted in 17OHP becoming the analyte of choice in 21OHD. Although 17OHP is the steroid typically studied in CAH, there are advantages to measuring 21-deoxycortisol, especially in infancy (205).

Description of Nonclassic CAH

By the late 1970s, several groups had reported individuals in whom signs of androgen excess—such as premature adrenarche, menstrual irregularity, hirsutism, or severe acne—developed postnatally, without evidence for adrenal insufficiency but with biochemical abnormalities, suggesting a mild form of 21OHD (206-208). Based on human leukocyte antigen (HLA) associations (see later), it appeared that this disorder—variously termed "late onset," "acquired," or "nonclassic" CAH—likely represented an allelic variant of "classic" CAH, and that some affected individuals ascertained in family studies were entirely asymptomatic and were said to have "cryptic" CAH (209). Lenore Levine and Maria New at Cornell developed data relating baseline and ACTH-stimulated blood levels of 17-hydroxyprogesterone, showing that individuals with nonclassic and classic CAH could be readily distinguished but that obligate heterozygous CAH carriers could not be reliably distinguished from unaffected individuals (210). The development of immunoassays for 17OHP in dried blood spots (211) made it possible to develop newborn screening for CAH with the aim of averting potentially fatal salt-wasting crises in neonates (212). This approach has proven successful and has been widely implemented [reviewed in (185, 213)].

Identifying the 21-Hydroxylase Enzyme

The determination that CAH was caused by a lesion in 21-hydroxylation led to efforts to isolate and characterize the responsible 21-hydroxylase enzyme. Ryan and Engel showed that steroid 21-hydroxylation by bovine adrenal microsomes was inhibited by carbon monoxide and that the reaction was reversible by light (214). Working on hepatic drug metabolism, Julius Axelrod (Nobel Prize in Medicine 1970) and Bernard Brodie had recognized the existence of an enzyme system in the endoplasmic reticulum that could oxidize xenobiotics, noting that the system was unusual in that it required both oxygen and reduced nicotinamide adenine dinucleotide phosphate (NADPH; then called TPNH) (215). They speculated that "these systems are not essential to the normal economy of the body, but operate primarily against the toxic influences of foreign compounds that gain access to the body"; this turned out to be incorrect, as P450 enzymes are essential to normal physiology, but it did lead to the discovery of cytochrome P450. In 1958, Martin Klingenberg and David Garfinkel (independently) identified a "carbon monoxide binding pigment" in liver microsomes with an absorbance at 450 nm (216, 217). Different personal views of the history of the discovery of P450 have been written by major players in this field (218-220).

Tsuneo Omura and Ryo Sato showed that this hepatic system involved a heme-protein that they named "cytochrome P450" (221), and they developed the classic procedure of

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P450 difference spectra to quantitate P450 (222, 223). Upon joining Ronald Estabrook's lab in Philadelphia in 1963, Omura demonstrated this CO-binding protein (or proteins) was also found in the adrenal cortex. David Cooper, Ronald Estabrook, and Otto Rosenthal developed the method and apparatus that showed that a cytochrome P450 was catalyzing 21-hydrozylation, as light at 450 nm reversed the CO inhibition (224, 225). (Figs. 16 and 17). The Cooper method established that 21-hydroxylase was a cytochrome P450. It took several more years to show that the P450 moiety actually was the catalytic component and not a generic cofactor (hence the outdated and incorrect term "P450-dependent enzyme"), but the discovery of P450-mediated 21-hydroxylation initiated the isolation of steroidogenic enzymes. The initial work with P450 concerned "microsomal" enzymes, but Hechter's lab showed that the cholesterol side-chain cleavage reaction occurred in mitochondria (226), leading to the demonstration of mitochondrial P450 by Simpson and Boyd (227, 228). Thus cytochrome P450 enzymes could be either microsomal or mitochondrial. It is now known that the human genome encodes 57 distinct P450 enzymes (229). As all of these enzymes are membrane-associated, purification of active enzymes depended on solubilization and stabilization with judiciously selected detergents. Although cytochrome P450 enzymes require auxiliary proteins for activity, these were not required to purify P450s, because P450 enzymes shift their absorbance spectra from a "low-spin" to a "high-spin" state upon binding the substrate, so that the presence of the enzyme during purification could be monitored by assessing the intensity of the difference spectrum in the various fractions.

Kominami, Takemori, and colleagues at Hiroshima University purified cytochrome P450c21 (now termed "CYP21A2") from bovine adrenal cortex microsomes by hydrophobic chromatography using an ω-amino-n-octyl Sepharose column in the presence of Emulgen 913, a nonionic detergent (231). The cytochrome P450 was immunochemically different from the mitochondrial cytochrome P450s catalyzing the side-chain cleavage of cholesterol and the 11β and 18 hydroxylation of 11-deoxycorticosterone (see later). The purified cytochrome P450 catalyzed C-21 hydroxylation of 17α-hydroxyprogesterone and progesterone when mixed with NADPH-cytochrome P450 reductase.

One of us (PCW) used this purification procedure while working in Bo Dupont's laboratory at Sloan-Kettering Institute and then generated a rabbit antiserum that he used to screen a bovine complimentary DNA (cDNA) library constructed in a primitive bacterial expression vector, thus isolating a partial cDNA for CYP21A2 (232). Full-length human cDNA (233, 234) was isolated subsequently.

Genetics of 21OHD

A major step in unraveling the genetic basis of 21OHD came from a collaboration between Bo Dupont and Lenore Levine, who found that siblings with 21OHD were almost invariably identical for HLA transplantation antigens. In the initial paper reporting 6 affected kindreds (235), 1 genetic recombination further localized the affected gene near the HLA-B locus. Additional papers from this collaboration confirmed HLA linkage and identified linkage disequilibrium (allelic associations at linked loci) between various forms of 21OHD and different HLA haplotypes (236). In particular, a small proportion of patients with classic CAH carried an unusual HLA haplotype, Bw47;DR7, whereas many patients with mild, nonclassic (also termed "late onset" or "cryptic") CAH carried HLA-B14;DR1 (237). Moreover, the HLA-Bw47;DR7 haplotype carried a null allele for 1 of the 2 *C4* genes encoding the fourth component of serum complement, which were known to be located in the HLA complex between HLA-B and HLA-DR. This made it extremely likely that this haplotype represented a contiguous gene syndrome, with a single deletion encompassing one of the *C4* genes and the as-yet-uncharacterized 21-hydroxylase gene (238). The Dupont lab isolated lymphocytes from a CAH patient who was homozygous for HLA-Bw47;DR7 (and thus presumably homozygous for a deletion of the 21-hydroxylase gene) and immortalized them with Epstein-Barr virus to have an unlimited source of DNA for further studies.

PCW and colleagues compared DNA from this cell line with normal DNA by Southern blot hybridization using their recently isolated partial length bovine cDNA clone. Hybridizing normal DNA digested with any of several

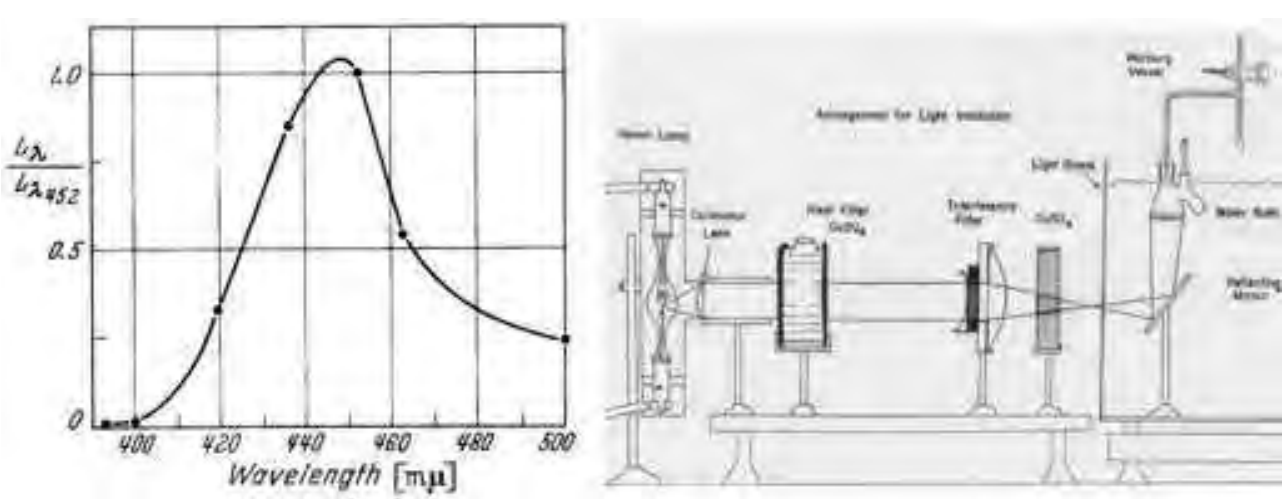

Figure 16. *Left,* Spectrum for the light-mediated reversal of the inhibition of bovine adrenal microsomal 21-hydroxylase by carbon monoxide [from (224)]. Right, Diagram of home-made apparatus built by Cooper et al to measure the reversal of CO-induced P450 spectrum and 21-hydroxylase activity of bovine adrenal microsomes [from (225); reprinted with permission].

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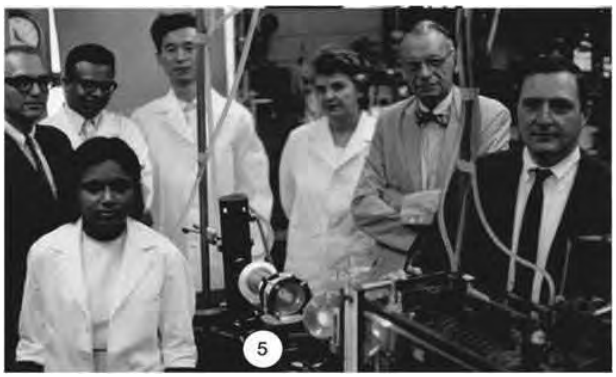

Figure 17. Cooper lab, 1964. Left to right: Levine, Slade, Narasimhulu, Omura, Foroff, Rosenthal, Cooper, and their homemade apparatus for measuring the photochemical action spectra of adrenal microsomal cytochrome P450 [from (230); reprinted with permission].

restriction enzymes produced 2 bands, whereas only 1 band was obtained using DNA from the CAH cell line, strongly suggesting that there were in fact two 21-hydroxylase genes and deletion of 1 of them could cause 21OHD (239). This was confirmed by isolating clones for the entire genomic region, which was greatly facilitated by the knowledge that the 21-hydroxylase genes were near the *C4* genes, and overlapping human (240, 241) and mouse (242, 243) genomic clones for that region were already available. It quickly became apparent that there was a tandem duplication in both humans and mice [in humans, this duplication encompassed 30 kilobasepairs (kb) of DNA], with 2 genes for *C4* alternating with 2 21-hydroxylase genes. One of us (WLM) showed that the bovine genome also contained 2 21-hydroxylase genes (244). In humans, the restriction endonuclease sites of the 21-hydroxylase gene adjacent to the *C4B* gene corresponded to the missing band in DNA from the patient with CAH. DNA from a cell line that was homozygous for a deletion of *C4A*, obtained from an otherwise normal individual, was indeed missing the bands corresponding to the 21-hydroxylase gene adjacent to *C4A*. These findings suggested that the 21-hydroxylase B gene (now termed *CYP21A2*) was the normally active gene but that the 21-hydroxylase A gene (*CYP21A1P*) was not functional. This was confirmed when sequences of the genes were obtained (234, 245), demonstrating that the genes were ~98% identical, but the 21-hydroxylase A gene was nonfunctional by virtue of at least 9 deleterious mutations.

Although the polymerase chain reaction (PCR) was proposed in 1985 (246), initially it could not be used to analyze the 21-hydroxylase genes because of their high degree of sequence similarity, which made it impossible to locate gene-specific primers close enough together to be practical with early polymerase chain reaction reagents. Thus the first point mutations were identified by screening genomic libraries constructed from DNA from patients with various forms of 21OHD. Surprisingly, all mutations identified in early studies (247-250) were also found in the 21-hydroxylase A pseudogene and were therefore presumably generated by gene conversion events. Expression of mutant enzymes in cultured cells (251) and comparison of the frequencies of different mutations in patients with different levels of disease severity (252, 253) demonstrated excellent genotype-phenotype correlations and established the salt-wasting, simple virilizing, and nonclassic forms of the disease as allelic variants. Based on genetic analysis of thousands of patients [summarized in (185)], 90% of alleles represent intergenic recombinations between the *CYP21A1P* pseudogene and *CYP21A2*. Approximately 20% are deletions of 30 kb generated by unequal crossing-over during meiosis (254), with the remainder representing gene conversions that could occur during meiosis or mitosis.

In San Francisco, WLM characterized several additional transcripts originating from the region of the 21-hydroxylase genes. Among these were 2 that were antisense to the 21-hydroxylase genes; one of these, originally termed XB (now termed *TNXB*), partially overlaps the *CYP21A2* gene for 21-hydroxylase and encodes tenascin-X, an extracellular matrix protein (255). Mutations of *TNXB* may occur without 21OHD and cause a severe, autosomal recessive form of Ehlers-Danlos syndrome (256), or partial deletions that also involve *CYP21A2* may cause a contiguous gene syndrome (257), now termed CAH-X, including both CAH and a milder form of Ehlers-Danlos syndrome (258). The history of Tenascin-X has been reviewed recently (259).

Other Forms of CAH

11β-hydroxylase deficiency (11OHD)

The existence of an 11β-hydroxylase had first been demonstrated by Hechter and Pincus (189), and a "hypertensive form" of CAH was first noted by Wilkins in his classic 1951 paper describing the first use of cortisone (177). Two patients had hypertension. A $3^1/_2$-year-old boy ("case 2") with virilization ("macrogenitosomia praecox"), enlarged adrenals seen at surgery, and testicular adrenal rest tumors had baseline blood pressure of 150/100, but his response to cortisone therapy could not be monitored because he developed mania and therapy was stopped. An 18½-year-old girl with "pseudohermaphroditism" (case 7) had progressive virilization, adrenal hyperplasia seen at surgery, and blood pressure of ~150/100 on most occasions. Treatment with 50 mg cortisol, initially daily but later on alternate days, reduced the pressure to 104/78. Later that year, Shepard and Claussen reported a 2½-year-old virilized "infant Hercules" with surgically proven adrenal hyperplasia and hypertension averaging 160/100; a 20-month-old sibling appeared to be similarly affected (260). Treatment with cortisone, initially at 40 mg/d and tapered to 10 mg on alternate days, normalized the blood pressure; further studies were not done. In his third follow-up paper on treatment of CAH, Wilkins described 3 patients with hypertensive CAH whose blood pressures normalized with cortisone (181), but studies of the basis of hypertension in these cases, as opposed to salt loss in other patients, were not pursued. As noted earlier, Bongiovanni had distinguished CAH caused by 21OHD from CAH caused by 11OHD in 1955, principally aiming to distinguish 21OHD from a variant form of CAH in which large amounts of tetrahydro-S (the metabolic product of 11-deoxycortisol or Reichstein's compound S) were excreted in the urine (215). They followed up that clinical report with detailed studies of the plasma and urinary steroids in this "hypertensive form of CAH" in which paper chromatography confirmed the presence of compound S in the blood and its metabolites in the urine (261). They concluded "No 11-oxygenated C21 or Cl9 steroids were detected in either the blood or urine. The abnormal steroid metabolites disappeared from the urine during administration

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of hydrocortisone. These findings suggest an essentially complete deficiency of adrenal '11β-hydroxylase' in the hypertensive form of congenital adrenal hyperplasia."

In the mid-1970s, teams at the University of California Irvine led by Peter Hall (262, 263) and at Kanazawa University led by Masayuki Katagiri and Shigeki Takemori (who later moved to Hiroshima University) (264) purified 2 distinct P450 cytochromes, termed "P450scc" and "P450c11," from bovine adrenocortical mitochondria. P450scc catalyzed the formation of pregnenolone from cholesterol, whereas P450c11 catalyzed the hydroxylation of deoxycorticosterone at 11β- and 18-positions. Partial length bovine P450c11 cDNA clones were isolated by Waterman's group (265) and used by White and colleagues to obtain more complete bovine and human cDNA sequences (266); bovine cDNA was independently isolated by Morohashi et al at Kyushu University in Fukuoka (267).

Attempts to isolate the human genomic gene for P450c11 revealed that there were, in fact, 2 genes: 1 (*CYP11B1*) expressed at high levels and the other (*CYP11B2*) at much lower levels (268). The second gene was expressed at much higher levels in RNA from an aldosterone-secreting adenoma. Expression studies (269) demonstrated that the enzyme encoded by *CYP11B1* had 11β-hydroxylase activity, whereas the enzyme encoded by *CYP11B2* also had strong 18-hydroxylase activity and was able to synthesize aldosterone starting from deoxycorticosterone. This latter enzyme was therefore termed "aldosterone synthase" and often referred to as P450aldo or P450c11AS. Similar findings were obtained in cattle (270).

Studies of deficiency states were facilitated by the fact that they occurred in specific populations. In Jews of Moroccan origin, 11OHD occurs relatively frequently: ~1/7000, greater than the frequency of 21OHD in most populations. All such patients carry the same mutation in CYP11B1, Arg-448 to His (R448H), which is located in a conserved peptide, which also contains the cysteine residue that represents the fifth ligand of the catalytic heme group (271).

Aldosterone Synthase Deficiency

The most frequent defect of aldosterone biosynthesis is 21OHD, but rare patients have aldosterone deficiency in the context of entirely normal cortisol and sex steroid synthesis. A detailed review of early reports of this disorder was published in 1981 (272). In 1961, Royer et al (273) at the Hopital des Enfants-Malades (Paris, France) described a brother and sister with profound salt wasting and severe aldosterone deficiency but no other clinical or biochemical features of CAH. Stanley Ulick in New York studied a similar patient in 1964, finding a low aldosterone secretory rate by isotopic dilution (measuring the radioactivity of urinary metabolites after injecting a known amount of radiolabeled aldosterone) but increased secretion of 18-hydroxycorticosterone (274). Similar findings were obtained by Visser and Cost in a study of 3 patients in the Netherlands (275): urinary aldosterone concentrations were undetectable, despite increased excretion of corticosterone, dehydrocorticosterone, and 11-deoxycorticosterone. The excessive production of aldosterone precursors was suppressed by treatment with exogenous mineralocorticoid, which also permitted resumption of normal physical growth and development. Additional studies (276, 277) revealed that different patients could have either increased or decreased secretion of 18-hydroxycorticosterone. This steroid was considered to be a biosynthetic intermediate resulting from the hydroxylation of the methyl group (C18) of corticosterone; the hydroxymethyl group would then be further oxidized to yield aldosterone. Ulick proposed (278) that these successive reactions be termed "corticosterone methyl oxidase (CMO) I and II," and that isolated aldosterone deficiency could be classified as either "CMO I" or "CMO II" deficiency, depending on whether 18-hydroxycorticosterone was decreased or increased, respectively. Although these data were consistent with 2 distinct enzymes acting in succession on corticosterone, Ulick observed (278, 279) that 18-hydroxycorticosterone was converted to aldosterone much less well than corticosterone when added to adrenal slices, suggesting (correctly) the possibility that corticosterone is converted to aldosterone by a single enzyme through an enzyme-bound intermediate.

A number of kindreds affected with CMO II deficiency were ascertained in a highly endogamous group of Jews originating from Isfahan, Iran, confirming an autosomal recessive mode of inheritance (280, 281). Levels of 18-hydroxycorticosterone were confirmed as being a reliable biochemical marker of the disease, particularly in affected adults, who often had normal electrolytes even without treatment. The disease in these kindreds was closely linked to polymorphisms in the *CYP11B* gene(s) (282) and eventually shown to result from homozygosity for 2 mutations in *CYP11B2*, Arg-181 to Trp (R181W) and Val-286 to Ala (V386A), with homozygosity for both mutations required to cause the disease (283).

Glucocorticoid-remediable Aldosteronism

In the mid-1960s, Laidlaw and colleagues in Toronto (284) and New and Petersen in New York (285) described similar patients with moderately severe hypertension from a young age, hypersecretion of aldosterone, suppressed plasma renin, and rapid reversal of these abnormalities after administration of glucocorticoids. In each case there was a similarly affected parent, strongly suggesting autosomal dominant inheritance. The lack of reliable biochemical markers initially made this condition—termed "dexamethasone-suppressible hyperaldosteronism" or "glucocorticoid-remediable aldosteronism"—difficult to ascertain, but by the mid-1980s markedly elevated levels of 18-hydroxycortisol and particularly 18-oxocortisol—to 20 to 30 times normal—were documented in affected patients (286-288). 18-Hydroxycortisol and 18-oxocortisol are 17α-hydroxylated analogs of 18-hydroxycorticosterone and aldosterone, respectively. Because 17α-hydroxylase is not expressed in the zona glomerulosa, the presence of large amounts of a 17α-hydroxy, 18-oxo-steroid, suggested that an enzyme with 18-oxidase activity (ie, aldosterone synthase, *CYP11B2*) was being abnormally expressed in the zona fasciculata, or alternatively that there was hyperplasia of a population of "transitional cells" that expressed all of the necessary biosynthetic enzymes (286). When the *CYP11B1* and *CYP11B2* genes were cloned, their patterns of expression identified, and the activities of the encoded enzymes determined, it was apparent that intergenic recombinations analogous to those causing 21OHD could create a chimeric gene that encoded a *CYP11B2*-like enzyme expressed like *CYP11B1* (269). Indeed, it was quickly shown by Lifton and colleagues (289, 290) (first studying an especially large affected kindred (291)) and by PCW

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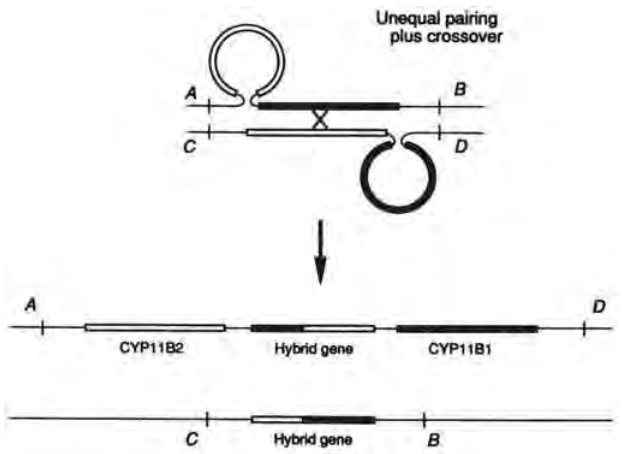

Figure 18. Unequal crossing-over between CYP11B1 and CYP11B2. CYP11B2 is on the left and pairs with the 95% similar CYP11B1. The direction of transcription is from left to right. A and C and B and D are homologous regions 5′ and 3′, respectively, of the CYP11B genes. A crossover between these paired genes during meiosis results in 1 gamete with duplicated genetic material, containing a hybrid gene with 5′ sequences from CYP11B1 and 3′ sequences from CYP11B2. The presence of a single copy of such an allele is sufficient to explain the features of glucocorticoid-remediable aldosteronism. The second gamete is deficient, containing only the complementary hybrid gene [from (292); figure provided by Prof. Perrin C. White].

and colleagues (292) that all patients with glucocorticoid-remediable aldosteronism have the same type of mutation, a chromosome that carries 3 *CYP11B* genes instead of the normal 2 (Fig. 18). The middle gene on this chromosome is a chimera with 5' and 3' ends corresponding to *CYP11B1* and *CYP11B2*, respectively. The chimeric gene is flanked by presumably normal *CYP11B2* and *CYP11B1* genes. The invariable presence of a chimeric gene in patients with this disorder suggests that this gene is regulated like *CYP11B1* (expressed at high levels in the zona fasciculata and regulated primarily by ACTH) but with enzymatic activity like the aldosterone synthase enzyme encoded by *CYP11B2*.

3β-Hydroxysteroid Dehydrogenase (3β-HSD) Deficiency

Leo T. Samuels, at the University of Utah, noted that all biologically active steroids are in the Δ^4 arrangement, with a double bond in the A-ring between carbons 4 and 5, and that "Cholesterol and Δ^5-3-ol intermediates are presumed to be precursors of the active hormones," and that hence "Various tissues were investigated for an enzyme that would convert the latter type of structure to the α,βunsaturated ketone" (293). He examined bovine ovarian follicles, corpora lutea and adrenal cortex, uterus, placenta, and liver and "three types of tumors of mice," finding that "only those tissues that normally form hormones with the α,βunsaturated ketonic structure contained the enzymes" could convert Δ^5-pregnenolone to an α,βunsaturated ketone as evidenced by the appearance of a strong absorption band at 238 to 240 mμ,"in the presence of DPN as a hydrogen acceptor." This was the first description of 3β-hydroxysteroid dehydrogenase (3β-HSD) activity. In 1956, Beyer and Samuels separated bovine adrenal homogenates into crude nuclear, mitochondrial, microsomal, and soluble fractions; activity was initially found in all fractions, with the highest activity per mg of protein in the microsomes, but after additional fractionation and washing procedures, they concluded that 3β-HSD activity was confined to the microsomes (294). This remained a dominant view, although multiple studies identified various subcellular locations [reviewed in (295)] until the use of immuno-electron microscopy showed that 3β-HSD was found in both microsomes and mitochondria (296).

Alfred M Bongiovanni, who had moved from Johns Hopkins to the University of Pennsylvania in 1954, identified the first patients with 3β-HSD deficiency. He published a preliminary "Letter to the Editor" describing 3 infants who died who had elevated urinary Δ^5 steroids (including 17KS) and unmeasurable urinary Δ^4 steroids; treatment with hydrocortisone (cortisol) normalized the excretion of urinary Δ^5 steroids (297). His follow-up paper reported 6 cases with both clinical and steroidal data and with citation to Samuels' 1951 *Science* paper (298). Three girls (2-7 weeks old) had minimal virilization (labial fusion) and salt loss; 2 boys (ages 8 weeks and 3 months) had hypospadias and salt loss, but the 6-year-old boy did not have salt loss. Because it is now known that genetically proven 3β-HSD deficiency is very rare (see later), Bongiovanni's accumulation of so many apparent cases of true 3β-HSD deficiency would seem to be incompatible with the very low incidence of this disorder. Recent work has identified a cluster of genetically homogeneous cases of 3β-HSD deficiency among the Old-order Amish population (299), which is centered in Pennsylvania's Lancaster and York counties, near Philadelphia; unfortunately, Bongiovanni's reports do not include family histories or ethnic information that might suggest whether this was the source of his cases.

Robust extra-adrenal 3β-HSD activity was reported in the early 1980s (300, 301); in retrospect this suggested that there must be at least two 3β-HSD enzymes, but that was not appreciated at the time. Enzymatic studies of enzymes purified from rat adrenals and testes (302) and human placenta (303) showed that a single polypeptide catalyzed both the hydroxysteroid dehydrogenase and isomerase activities and was found in both the microsomes and mitochondria (303, 304). Human placental 3β-HSD (later designated type I) cDNA was isolated and characterized by Fernand Labrie's group in Quebec (305) by expression screening using a polyclonal antibody to the purified enzyme (303) and independently by Ian Mason and colleagues (306). The second human 3β-HSD isoenzyme, chronologically designated as type II, was isolated from a human adrenal cDNA library (307). Transient expression of human 3β-HSD isoenzymes demonstrated that the 3β-HSD and Δ^5-Δ^4-isomerase activities reside within a single protein (306, 307).

Both 3β-HSD isozymes could convert the Δ^5-steroids [pregnenolone, 17-hydroxypregnenolone, dehydroepiandrosterone (DHEA), and androstenediol] to the corresponding Δ^4-steroids (progesterone, 17OHP, androstenedione, testosterone), but the placental/hepatic HSD3B1 had a low Michaelis-Menten constant (Km), permitting it to act on low concentrations of steroids in the circulation, whereas the Km for the adrenal/gonadal HSD3B2 was 10-fold higher, acting only on locally produced, intraglandular steroids. There are 2 human HSD3B genes: *HSD3B1* encodes the isozyme found in the placenta, brain, liver, and elsewhere, and *HSD3B2* encodes the enzyme found in the adrenals and gonads (306, 308, 309). These are clustered on chromosome 1p13 along with 5 pseudogenes (310). Mutations in *HSD3B2* cause CAH due to 3β-HSD deficiency (311). Mutations in *HSD3B1* have not been reported. Genetically proven 3β-HSD

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deficiency is very rare, and many individuals are seen in mid-childhood with premature adrenarche who appear hormonally to be have mild 3β-HSD deficiency but in whom no genetic lesion can be found [reviewed in (295)].

17α-Hydroxylase and 17,20-Lyase Deficiencies

Edward G. Biglieri (1925-2005), a gifted steroid chemist, established the UCSF General Clinical Research Center at San Francisco General Hospital in 1963 (312). He soon encountered a "prismatic case": a 35-year-old woman with hypertension and hypokalemia who had been sickly in childhood and adolescence, who also had primary amenorrhea and sexual infantilism. Her urine lacked metabolites of cortisol, but the 17KS assay yielded a muddy brown color instead of the expected clear lavender (313). Biglieri developed an assay for urinary tetrahydro-DOC and found it was very high, accounting for the unexpected color in the 17KS assay; the secretory rate of corticosterone was also high. These data, coupled with the sexual infantilism and absent assayable sex steroids, indicated 17-hydroxylase deficiency (314).

Converting C21 steroids to the C19 precursors of sex steroids requires 17,20-lyase activity. Biglieri's patients with 17-hydroxylase deficiency did not produce sex steroids, but it was not clear if this was because a single enzyme catalyzed both reactions or reflected an absence of precursor 17OH steroids. In 1972, a paper reported apparent isolated 17,20-lyase deficiency (315), appearing to demonstrate that 17-hydroxylase and 17,20-lyase were separate enzymes. Clinical studies in healthy children suggested that adrenal 17-hydroxylase activity (as indicated by serum cortisol) is fairly constant throughout life, whereas adrenal 17,20-lyase activity [indicated by DHEA and dehydroepiandrosterone sulfate (DHEAS)] is low in early childhood, rising rapidly during adrenarche at 8 to 10 years of age (316), supporting the belief that 17-hydroxylase activity and 17,20-lyase activity were catalyzed by separate enzymes. However, Peter Hall's laboratory, which had moved to the Worcester Foundation for Experimental Biology, showed that both activities were found in a single microsomal P450 enzyme isolated from pig testes, the first demonstration that distinct steroid biosynthetic steps could be catalyzed by a single enzyme (317, 318). Nevertheless, this concept remained controversial. The first cDNA for the P450 catalyzing 17-hydroxylase activity (P450c17, later termed CYP17A1) was isolated by Michael Waterman's laboratory in Dallas by screening a bovine adrenal cDNA library with probes made from size-fractionated mRNA from ACTH-treated bovine adrenocortical cells; the correct size fraction was identified by hybrid-selected translation and immunoprecipitation using a specific CYP17A1 antiserum, and a negative control was prepared from cells that had not been treated with ACTH (319). This group then transfected nonsteroidogenic mammalian COS-1 cells with a vector expressing this cDNA, showing that the cells acquired both 17-hydroxylase and 17,20-lyase activities, thus establishing that this 1 enzyme catalyzes both activities (320).

Contemporaneously, WLM collaborated with Peter Hall and with John Shively's laboratory at Beckman Research Institute of the City of Hope in Duarte, California; they obtained an 83% complete amino acid sequence of porcine CYP17A1 and used this amino acid sequence data to construct degenerate oligonucleotide probes used to screen a porcine adrenal cDNA library, yielding a short partial sequence. The porcine cDNA was then used to screen their human adrenal cDNA library and a commercially obtained human testicular cDNA library, yielding identical CYP17A1 sequences from both sources, demonstrating that the same gene is expressed in both tissues (321). Waterman and colleagues also isolated human cDNA and expressed it in COS-1 cells, demonstrating that it had similar activity to the bovine enzyme (322). The full-length gene, now termed *CYP17A1*, was then cloned and sequenced, showing it is most closely related to the *CYP21A2* gene encoding steroid 21-hydroxylase (323).

The first mutation in *CYP17A1*, in a patient with both 17-hydroxylase and 17,20-lyase deficiencies, was reported in 1988 (324). Genetically proven cases of isolated 17,20-lyase deficiency appeared later: some patients had mutations in *CYP17A1* (325, 326), others had mutations in cytochrome b_5 (325, 326), and 1 had a mutation in P450 oxidoreductase (327). These reports show that 17,20-lyase deficiency is a syndrome, not a single disease (328). The patients originally reported in 1972 (315) were eventually found to have mutations in the AKR1C2 and AKR1C4 enzymes in the alternative "backdoor pathway" of androgen synthesis, thus they did not have 17,20-lyase deficiency (329).

P450 Oxidoreductase

P450 oxidoreductase (POR), the enzyme that transfers electrons from NADPH to microsomal cytochrome P450 enzymes, also transfers electrons to many other recipients, hence it was discovered independently in multiple contexts. Early studies identified it as an NADPH-dependent (then called TPNH-dependent) cytochrome c reductase (330, 331) and other studies showed it was required for microsomal P450-mediated hydroxylation reactions (215, 332, 333). POR was then localized to the endoplasmic reticulum (334, 335) and linked to the activities of microsomal P450 enzymes (336), but it was not until 1969 that it was proven that P450 and POR were distinct membrane-bound proteins that interact with one another (337). All of these early biochemical studies assayed POR activity by its capacity to reduce cytochrome c. However, cytochrome c is a mitochondrial protein that does not encounter microsomal POR within a cell; thus, this simple, time-honored assay was convenient but not physiologic, and turned out to be unreliable for assessing the residual activity of disease-causing POR mutants and other human POR variants (338). Analysis of the activities of multiple P450 enzymes supported by different POR variants has shown that no single assay describes POR activity; its activity must be assayed with the specific form of P450 (or other electron recipient) that is being studied (338, 339).

In 1985, Peterson et al described a patient with genital ambiguity and an abnormal urinary steroid profile suggesting partial combined deficiencies of 17α-hydroxylase, 17,20-lyase, and 21-hydroxylase (340). Knowing that these activities were catalyzed by microsomal cytochrome P450 enzymes that must receive electrons from POR, WLM suggested that this patient had a disorder in POR (341) but was unable to obtain any patient samples. Others sought mutations in the *CYP17A1* gene (342) and *CYP21A2* gene (343), but none were found. Investigators addressing the genetics of drug metabolism created POR knockout mice (344, 345). These knockouts were lethal; the animals probably died due to disruption of extrahepatic P450 enzymes, as liver-specific knockout of POR produced phenotypically normal, reproductively competent

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mice that had markedly impaired hepatic drug metabolism (346, 347). Similarly, globally hypomorphic POR mice also had impaired hepatic drug metabolism (348). The hypothesis that a POR mutation might explain Peterson's findings was thought to be incompatible with this embryonic lethality of POR-knockout mice. Thus the POR hypothesis lay dormant until DNA became available to WLM's lab from such patients, resulting in the first reported cases of POR deficiency (349). This initial report included 3 patients who also had the Antley-Bixler skeletal malformation syndrome (ABS) (characterized by craniosynostosis, midface hypoplasia, radiohumeral or radioulnar synostosis, arachnodactyly, and bowing of the femora), and 1 who had PCOS without ABS. Fibroblast growth factor receptor 2 (FGFR2) mutations cause ABS without defective steroidogenesis (343). Peterson's original patient from 1985 also had no reported skeletal anomalies; a large study of a heterogeneous population demonstrated the independent segregation of POR and FGFR2 mutations. The steroidogenic disorder, with or without ABS, was caused by recessive POR mutations, whereas ABS without disordered steroidogenesis was caused by dominant FGFR2 mutations (350). POR deficiency is now a well-understood pediatric endocrine disorder that has expanded understanding of POR (351).

3′-Phosphoadenosine 5′-Phosphosulfate Synthase 2 Deficiency

Besides POR deficiency (Antley-Bixler syndrome), another example of discovering an adrenal defect hiding in a skeletal dysplasia syndrome concerns 3'-phosphoadenosine 5'-phosphosulfate synthase 2 (PAPSS2) deficiency. Many tissues make DHEA, but only the adrenal converts DHEA to DHEAS, catalyzed by SULT2A1, a sulfotransferase (352). SULT2A1 uses 3'-phosphoadenine-5'-phosphosulfate (PAPS) as its sulfate donor, which in turn is synthesized by PAPSS2 in the adrenal and cartilage (353). PAPSS2 deficiency was first reported in a Pakistani family with the rare skeletal defect "spondyloepimetaphyseal dysplasia/brachyolmia type 4" (MIM #603005) (354), but steroidal assays were not included in this or other early reports. In 2009, a 6-year-old girl evaluated for clinical hyperandrogenism had elevated circulating DHEA, androstenedione, and testosterone but no DHEAS, suggesting a defect in SULT2A1. No mutations were found in the *SULT2A1* gene, but the patient had compound heterozygous *PAPSS2* mutations; she also had minimal vertebral anomalies only seen radiographically (355). SULT2A1 cannot function in the absence of PAPSS2, resulting in overproduction of unconjugated C19 androgen precursors and consequent virilization (356).

Acute and Chronic Regulation of Adrenal Steroidogenesis

In the history of hormone purification, epinephrine (69, 70) and thyroxine (85) came first, followed by a succession of polypeptide hormones, including insulin (86), parathyroid hormone (89), and others; these successes were primarily due to the abundant storage of these hormones in their tissues of synthesis. Isolation of steroid hormones, as described in "Finding Steroid Hormones: Early Studies of Adrenal Steroid Chemistry," was substantially more difficult because of the very small amounts of hormone present in steroidogenic glands. This dichotomy suggested that the regulation of steroid synthesis and release differed fundamentally from the mechanisms regulating these processes for polypeptide hormones. Histologic studies identified eosinophilic granules (secretory vesicles) in cells producing polypeptide hormones, suggesting that these cells stored previously synthesized protein hormones for rapid release, but no such granules were found in steroidogenic cells. Thus a major question became how steroid hormone synthesis and release were regulated. In 1943, Marthe Vogt at the University of London showed that, in comparison to the amounts extractable from tissues, adrenal glands produce large amounts of corticoids, calculating that, in 1 day, a 10 kg dog secretes the amount of corticosteroid found in 17.3 kg of adrenal tissue (357). This indicated ongoing steroid synthesis and presaged the realization that steroid synthesis and release are directly linked, with little intraglandular storage. The infusion of steroidal precursors into the artery of isolated bovine adrenals and measurement of steroids in the venous effluent yielded the first pathways of corticosteroid biosynthesis [reviewed by (193)] and showed that ACTH stimulated steroid biosynthesis (191).

Chronic Effects of ACTH

ACTH affects the adrenal at 3 distinct physiologic levels. The first action to be identified was the slowest: the very-long term promotion of adrenal growth, as hypophysectomy in dogs profoundly reduced adrenal weight (358). The role of the pituitary in maintaining adrenal weight was confirmed by Philip E. Smith (91, 92), and, in 1930, James B. Collip, famous for devising the successful purification procedure for insulin used in 1923, reported preliminary purification of an "adrenotropic hormone" that stimulated rat adrenal growth (359). In the absence of a simple, rapid assay, efforts to purify ACTH languished until Stone and Hechter showed that ACTH promoted conversion of cholesterol to pregnenolone—the birth of the field of "steroidogenesis" (191).

The second, temporally intermediate, action of ACTH [or luteinizing hormone (LH)] is to stimulate [via 3′,5′-cyclic adenosine 5′-monophosphate (cAMP)] the transcription of genes encoding the steroidogenic enzymes, especially the rate-limiting cholesterol side-chain cleavage enzyme, P450scc (now termed CYP11A1). In cultured bovine adrenal cells, ACTH induced accumulation of CYP11A1 mRNA within 8 hours (360), and the kinetics of the increase in CYP11A1 mRNA were paralleled by the increased steroid secretion by human granulosa cells cultured with hCG (361). These 2 actions, on adrenal growth and adrenal gene transcription, constitute the "chronic response."

ACTH preparations were quickly employed clinically to assess adrenal function. An initial assay for primary adrenal insufficiency measured the fall in the eosinophil count after an injection of ACTH (362), but this test lacked specificity, given that epinephrine produced the same effect. By the early 1950s, urinary cortisol metabolites (17-hydroxy corticoids) could be measured readily. In a 1953 editorial in the *Journal of Clinical Endocrinology & Metabolism,* George Thorn at Harvard suggested a procedure comprising a baseline 24-hour urine collection, followed by an 8-hour continuous intravenous infusion of 20 to 25 units of ACTH (this is equivalent to 250 mcg, similar to the modern test), followed by a second urine collection for 24 hours (including the 8-hour infusion) and analyzed for 17-hydroxycorticoids. He suggested that secondary adrenal insufficiency—including iatrogenic adrenal suppression from hydrocortisone treatment—could be distinguished by a subnormal response to a single intravenous

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infusion but with a gradual improvement in response to infusions repeated over several days. Long-acting ACTH preparations were developed to stimulate the chronic response; "Acthar Gel" was developed by Armour & Company, a meatpacking company, and approved by the Food and Drug Administration in 1952 for multiple inflammatory diseases as a long-acting substitute for oral steroids; American Cyanamid Corp. established the complete 39 amino acid sequence of pig ACTH and showed that residues 1 to 24 were sufficient for full biological activity, providing the basis for the synthetic cosyntropin used today (363).

Acute Effects of ACTH

The third, and most rapid, response of steroidogenic cells to tropic stimulation is the mobilization of cholesterol from cellular stores to move to the outer mitochondrial membrane and its transfer to the inner mitochondrial membrane. This constitutes the "acute steroidogenic response." In the 1960s Ferguson (364) and Garren (365, 366) used inhibitors of protein synthesis (cycloheximide or puromycin) to show that the action of ACTH on the adrenal was not direct but required the synthesis of 1 or more additional protein(s). Garren et al also showed that this action of ACTH was rapid and that the cycloheximide-sensitive protein(s) had a short half-life (365). In the late 1960s, Simpson and Boyd had shown that all steroidogenesis begins with the conversion of cholesterol to pregnenolone by the mitochondrial cholesterol side-chain cleavage enzyme P450scc (CYP11A1) (227, 228). That enzyme system is very slow and is the enzymatic rate-limiting step (367). However, because cholesterol is insoluble in water, other factors are needed for it to reach the mitochondria to initiate steroidogenesis; this constitutes the rate-limiting step in steroidogenesis (368). These and other studies, elegantly reviewed in detail by Stocco and Clark (369), led to the model that the acute regulation of steroidogenesis required a hormonally stimulated, rapidly synthesized, labile protein that appeared to mediate the transfer of cholesterol across the 2 mitochondrial membranes to reach CYP11A1. Several candidates were proposed to function as this acute regulator of steroid biosynthesis, but essential roles for all of these proteins were eventually ruled out [reviewed in (370)].

The responsible protein was independently identified by Nanette R. Orme-Johnson and colleagues at Boston University and Douglas M. Stocco at Texas Tech University, using 2-dimensional gel electrophoresis of newly synthesized proteins labeled with radioactive phosphorus. Orme-Johnson identified a 30 kDa ACTH-induced mitochondrial phosphoprotein in mouse adrenocortical cells, and a similar LH-induced protein in rat corpus luteum cells and mouse Leydig cells (371-374), the appearance of which was temporally related to the induction of steroid hormone biosynthesis. Stocco and colleagues identified a similar candidate mitochondrial protein in mouse MA-10 Leydig cells (375, 376). When cDNA encoding this protein was isolated and constitutively expressed in MA-10 cells, it induced steroid hormone synthesis even in the absence of LH stimulation; Stocco termed this protein the "steroidogenic acute regulatory" protein (StAR) (377). The essential role of StAR in steroidogenesis was proven when WLM, collaborating with Stocco and others, showed that its coexpression with the CYP11A1 system in nonsteroidogenic cells induced steroidogenesis and that StAR mutations cause congenital lipoid adrenal hyperplasia (378).

Lipoid CAH

The first reports of lipoid CAH preceded the studies that led to the discovery of StAR. In Zurich in 1955, Andrea Prader (1919-2001) described a 6-week-old phenotypic female who died in an Addisonian crisis; her autopsy showed huge adrenals; no uterus, tubes, or ovaries; and no Barr bodies. Unfortunately, no steroid data were reported (379). Also in 1955, AT Sandison, a pathologist in Glasgow, reported a 3-month-old infant who also died in apparent Addisonian crisis; she had a normal uterus, tubes, and ovaries and lipid deposits confined to the massively enlarged adrenals (Fig. 19); again, no steroid data were reported (380). Prader described a second case successfully treated with glucocorticoids who succumbed to infection; based on the histologic appearance of the autopsied adrenals, he termed the disorder "lipoid CAH." He discussed the clinical manifestations in genetic males and females but suggested his patients had defective conversion of Δ^5 to Δ^4 steroids (381). Other early clinical reports (382, 383) added no mechanistic insight.

Shimizu et al had shown that conversion of cholesterol to pregnenolone proceeded via 20α-OH and 22-OH intermediates, suggesting there were 3 enzymes: 20α-hydroxylase, 22-hydroxylase, and 20,22-desmolase (384). Conversion of cholesterol to pregnenolone required mitochondrial P450scc (CYP11A1) (227). Camacho et al concluded that lipoid CAH involved defective conversion of cholesterol to pregnenolone but did not study how this might happen (385). In 1972, Degenhart et al showed that normal adrenal mitochondria converted cholesterol to pregnenolone but that mitochondria from an autopsied patient with lipoid CAH did not; however, they also showed that the lipoid CAH mitochondria could convert 20α-hydroxycholesterol to pregnenolone, suggesting defective 20α-hydroxylation (386). This conclusion was logical but incorrect, because soluble hydroxysterols such as 20α-hydroxycholesterol

Figure 19. A sectioned adrenal gland from a patient with congenital lipoid adrenal hyperplasia, termed "lipidosis of the adrenal." [from Sandison (380); reprinted with permission].

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(and unlike cholesterol) can freely diffuse into the mitochondria, where CYP11A1 resides. In 1977, Koizumi et al reported that mitochondria from another patient with lipoid CAH failed to convert cholesterol to pregnenolone but had normal 11β- and 18-hydroxylase activities; they suggested that the lipoid CAH mitochondria specifically lacked CYP11A1 (387). This study, in conjunction with Camacho's 1968 clinical report (385), led to lipoid CAH becoming regarded as a defect in the conversion of cholesterol to pregnenolone, and the disorder was incorrectly termed "20,22 desmolase deficiency."

The enzyme termed "20,22 desmolase" was, in fact, mitochondrial P450scc (CYP11A1) (227). In 1973, Peter Hall and colleagues, then at the University of Calironia Irvine, isolated CYP11A1 from bovine adrenocortical mitochondria (262, 388). Partial clones for the corresponding bovine cDNA were isolated by Michael Waterman's lab in Dallas (360); the first full-length bovine clone was obtained by Morohashi et al in Omura's lab in Fukuoka (389). WLM used very long, 72-base synthetic oligonucleotides corresponding to segments of the bovine cDNA to show that the corresponding gene was not deleted in patients with lipoid CAH and to clone a partial-length (818 bp) human cDNA (390), which was then used to clone the full-length human cDNA (391). To elucidate the basis of lipoid CAH, WLM sought mutations in CYP11A1, its electron-donating cofactors, or candidate factors thought to facilitate cholesterol entry into mitochondria, but all were normal (392); thus, lipoid CAH was not "20,22 desmolase" deficiency. That study pointed out that infants with lipoid CAH reached term normally, indicating that placental synthesis of progesterone was unaffected, concluding: "Thus, a molecular model of lipoid CAH should implicate a gene involved in adrenal and gonadal, but not placental steroidogenesis." Following the cloning of mouse StAR (377), Douglas Stocco, Jerome F. Strauss III in Philadelphia, and WLM collaborated on cloning human StAR and showed that it is expressed in the adrenals and gonads but not placenta (393); before that paper was in print, this team identified StAR's role in lipoid CAH (378). The complex physiology of the disease was explained by the "2-hit" model (394), subsequently confirmed in clinical studies (395, 396) and in knockout mice (397). A milder, "nonclassic" form of lipoid CAH, without phenotypic sex reversal in 46,XY patients but with compensated glucocorticoid deficiency, mild hypergonadotrophic hypogonadism, and occasionally mildly disordered mineralocorticoid secretion was described in 2006 (398).

CYP11A1 (P450scc) Deficiency

Discovering that lipoid CAH was due to StAR mutations did not prove that a similar syndrome was not caused by defects in CYP11A1 or its electron transfer proteins. However, in 1991 Lin et al (392) pointed out that lipoid CAH patients reached term normally and that term gestation requires placentally produced progesterone (to suppress uterine contractility), indicating that the CYP11A1 system functioned normally in the placentas of lipoid CAH fetuses. This suggested that no one would have CYP11A1 deficiency. That logical supposition was falsified when Toshehiro Tajima and Kenji Fujieda at Hokkaido University encountered a patient with the hormonal features of lipoid CAH but with normal StAR genes on both alleles; further genetic sleuthing revealed a heterozygous *CYP11A1* mutation (399). The unexpected mutation of CYP11A1 was soon confirmed in other patients, but the manifesting heterozygosity in the Tajima/Fujieda patient remains unexplained (400). A milder, nonclassic form of CYP11A1 deficiency has been reported that is similar to nonclassic lipoid CAH (401).

Familial Glucocorticoid Deficiency

Familial unresponsiveness to ACTH

In 1959 Shepard and colleagues at the University of Washington (402) described 2 sisters who, in their second year of life, developed hyperpigmentation, weakness, and later convulsions. Both children were large for their age. The first child died at 30 months, and autopsy revealed marked adrenocortical atrophy with some clusters of cells remaining only in the zona glomerulosa. The pituitary gland was largely composed of small cells with pale cytoplasm—a finding similar to what was seen in patients dying of Addison's disease. Her sister presented at 28 months with a blood glucose of 10 mg/dl, but electrolytes were normal. She was unresponsive to intramuscular ACTH but responded well to intramuscular cortisone with resolution of hyperpigmentation and muscle weakness. Aldosterone secretion was normal. The authors considered and ruled out CAH, autoimmune Addison's disease, panhypopituitarism, and adrenal insufficiency associated with hypoparathyroidism and moniliasis (ie, APS-1)—a remarkably complete differential for 1959. In 1968 Claude Migeon and colleagues described 6 such patients in 5 kindreds; 3 patients each had at least 1 sibling who had died in infancy or early childhood (403). These patients all responded clinically to cortisone but not to ACTH. An adrenal biopsy was attempted in 1 patient that became a total unilateral adrenalectomy. Histology showed preservation of the zona glomerulosa but absence of the zona fasciculata. Incubation of tissue slices with ACTH produced no response, whereas incubation with cAMP produced a marked increase in corticosterone (but not cortisol) production, suggesting that the lack of ACTH responsiveness was not a consequence of defective cAMP signaling. These authors named this syndrome "congenital adrenocortical unresponsiveness to ACTH," thus specifying a mechanism. Very high levels of ACTH were subsequently documented in similar patients (404). These facts made it likely that at least some cases were the result of mutations in an as-yet-unidentified cellular receptor for ACTH. Unfortunately, these latter authors used the term "familial glucocorticoid deficiency," which did not specify a mechanism and permitted the application of this term to several unrelated disorders.

In 1992, Roger Cone and colleagues at Oregon Health Sciences University cloned 2 melanocortin receptors by PCR-amplifying cDNA fragments from a human melanoma cell line that contained a high level of binding sites for melanocyte-stimulating hormone (MSH), using relatively nonspecific primers recognizing conserved portions of G-protein coupled receptors (405). After determining by Northern blotting that their clones bound to RNA from melanocytes and the adrenal cortex, they isolated genomic clones for 2 related but distinct genes. Expression of the corresponding cDNAs in cultured cells demonstrated that cells transfected with 1 of them increased cAMP levels in response to α-MSH, whereas the other induced responsiveness to ACTH. Within 6 months, Adrian Clark and colleagues in the United Kingdom identified a

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mutation in the ACTH receptor gene (now termed "MC2R") in a patient with familial glucocorticoid deficiency (406) and subsequently demonstrated that the receptor was impaired functionally (407); thus these patients truly had unresponsiveness to ACTH. Chrousos and colleagues at the National Institutes of Health identified mutations in another patient shortly thereafter (408), but it quickly became clear that the term "familial glucocorticoid deficiency" was being applied to patients with a wide array of disorders not linked to *MC2R* (409). Some of these patients carried mutations in the *MRAP* gene encoding the melanocortin 2 receptor accessory protein, which interacts with MC2R and may be required for tracking of MC2R from the endoplasmic reticulum to the cell surface (410).

Other disorders have been misdiagnosed as familial glucocorticoid deficiency, such as nonclassic lipoid CAH (411). The study of genetic defects of aldosterone biosynthesis such as 21OHD (see "Genetics of 21OHD") and aldosterone synthase deficiency (see "Aldosterone Synthase Deficiency") has shown that a very small amount of aldosterone biosynthetic capacity is sufficient to prevent clinical aldosterone deficiency. Thus some patients with putative selective glucocorticoid deficiency may, in fact, have more generalized adrenal insufficiency that is not quite severe enough to cause aldosterone deficiency.

Addison-achalasia-alacrima syndrome

In 1974, West and Counahan at the Great Ormond Street Hospital in London reported a boy with isolated glucocorticoid deficiency with normal mineralocorticoid function, alacrima, and dystrophic changes in the skin of the fingertips, with alacrima in a younger brother (412). Four years later, Allgrove and colleagues at the same institution (413) reported that the younger brother now also had adrenal insufficiency and that both brothers had also developed achalasia of the gastric cardia. A biopsy obtained during myotomy of the lower esophageal sphincter to relieve dysphagia showed that the muscle lacked nerve fibers. The authors reported the identical combination of findings in a brother and sister from a separate family. On inquiring of colleagues at other institutions, they learned that a previously reported patient at the University of California San Francisco with familial unresponsiveness to ACTH (414) had subsequently developed achalasia. They concluded that this combination of findings represented a familial disorder of unknown etiology. In the first year after diagnosis, cortisol secretion in 1 patient was unresponsive to ACTH but did increase in response to theophylline, a phosphodiesterase inhibitor, suggesting a defect in ACTH signaling (415). This syndrome is termed the achalasia-ACTH insensitivity-alacrima (triple A) syndrome (416) or, eponymously, Allgrove syndrome (417). The affected gene, *AAAS*, was identified by positional cloning techniques (418). The gene product, aladin, contains WD repeats and is a nuclear pore protein. It interacts with ferritin heavy chain; mutations in *AAAS* interfere with nuclear importation of ferritin, rendering the nucleus susceptible to oxidative damage (419).

Adrenocortical Cell Lines and the Elucidation of Trophic Signaling Pathways

Two cell lines have played major roles in mechanistic studies of the regulation of adrenal steroidogenesis [reviewed by (420)]. The first is the mouse Y1 cell line, which was derived from a tumor that arose in an adult C57L × A/HeJ male mouse following exposure of the mouse to an atomic blast. The tumor produced corticosterone and responded to ACTH with increased rates of steroidogenesis (421). It was propagated by intramuscular transplantation. Gordon Sato and colleagues (422) adapted this transplantable tumor to grow ex vivo, and the Y1 cell line was cloned from this culture-adapted tumor (423) and deposited with the American Type Culture Collection. The cloned cells can no longer synthesize corticosterone due to loss of 21-hydroxylase activity; they synthesize 20α-dihydroxyprogesterone and 11β,20α-dihydroxyprogesterone (424, 425). However, the cells remain responsive to ACTH, which causes a 4- to 10-fold increase in steroid production over baseline (426). Y1 cells were particularly valuable in identifying transcription factors important for adrenal-specific gene expression.

Y1 cells stop growing, change shape, and detach from the substratum when treated with agents that raise the intracellular levels of cAMP. These effects drastically reduce the plating efficiency of cAMP responsive cells and permit the recovery of rare drug-resistant mutants. Several such mutant lines carry dominant-negative mutations in the type 1 regulatory subunit of protein kinase A (427, 428). These mutants have been used to demonstrate that cAMP and protein kinase A are essential components for ACTH-mediated upregulation of steroidogenesis and gene expression.

The second is the human NCI-H295 cell line and its derivatives, particularly H295R. The original NCI-H295 cell line was derived in 1980 from a large adrenocortical carcinoma in a 48-year-old woman who presented with weight loss, acne, facial hirsutism, edema, diarrhea, and a recent cessation of menses (429). Based on secreted steroids, these cells apparently contained all major adrenocortical enzyme systems including CYP11A1, HSD3B2, CYP11B1, CYP21A2, CYP17A1, CYP11B2, 3β-hydroxysteroid dehydrogenase, and low levels of aromatase (CYP19). Studies of these cells, which grew in suspension, confirmed the expression of all the principal adrenal steroidogenic enzymes and that the mRNAs for these enzymes were responsive to cAMP (430). The H295R substrain was derived from the parental line using alternative growth conditions to encourage substrate attachment and shorter cell cycle times.

Although H295 and H295R are not ACTH responsive, H295R cells do respond to activation of the cAMP-dependent pathway with either forskolin (to activate adenylyl cyclase) or cAMP analogues (430, 431). Moreover, they respond to angiotensin II and have proven invaluable for studying the regulation of aldosterone biosynthesis. H295R cells express the AT1 receptor for angiotensin II (432); this is coupled to phosphoinositidase C and increases the production of inositol phosphates and cytoplasmic free calcium. The other major physiologic regulator of adrenal aldosterone production is extracellular K^+ levels. K^+ increases intracellular calcium levels in H295R cells by triggering a voltage-activated calcium channel (433).

Developmental Stages

The Fetal Adrenal

Unlike most mammals, human fetuses have huge adrenals. This strange fact has fascinated and perplexed endocrinologists for over a century. The fetal adrenal was first described

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in 1910 by Stella Starkel and Leslaw Wegrzynowski (434), medical students at the University of Lwów in Poland, who later married (435). Their survey of about 100 adrenals from 6 months gestation through 5 years of age reported the rapid involution of the fetal adrenal following birth. The following year, 3 similar reports appeared describing "involution" or "degeneration" of the fetal zone (436-438); other anatomists confirmed and expanded this observation, pointing out that the combined adrenal weight at birth was about equal to the combined weight of adult adrenals (8-9 g) (438, 439) but soon involuted to a total weight of about 2 g (440-442), accompanied by a parallel diminution in the synthesis and secretion of DHEA and DHEAS (440-442). The rapid, postnatal involution of the fetal adrenal was described as "necrosis" by Benner (443), but De Sa reported this was a postmortem artifact (444), leading to the view that the fetal zone was "remodeled" into ZF. In 1955, Beatty and Hawes concluded: "During the first month of life, degenerative changes take place in the cortex which are apparently physiologic. This degeneration of the fetal cortex appears to be initiated by the birth processes and is unrelated to the gestational age of the infant. These changes, which reduce the adrenal cortex to near adult proportions, are not seen in the ordinary laboratory animal" (445). A more modern view is that fetal adrenal involution may be mediated by apoptosis (446).

The role of the fetal adrenal in human physiology has been unclear and controversial. The huge fetal adrenal size and tremendous output of DHEA and DHEAS suggested a major role, leading to the concept of the "feto-placental unit," wherein the fetal adrenal provides the C19 steroid precursors for placental conversion to estrogens (447). However, these phenomena are unusual among mammals and are only seen in a few primates, questioning whether they were essential. It was soon shown that fetuses that cannot synthesize C19 steroids because of steroidogenic disorders or adrenal hypoplasia congenita developed normally and reached term, as did fetuses that lack estrogen receptors. Thus an essential role for feto-placental estrogens and the fetal adrenal has not been established.

Most 20th-century studies of fetal adrenal involution relied on postmortem histology; newer studies showed that DHEAS declined by 50% within a week of parturition, and adrenal ultrasonography showed more rapid adrenal involution, within 2 weeks (448). As suggested previously (445), these authors concluded that the trigger to fetal adrenal involution was parturition itself and suggested that the mechanism was withdrawal of a placental hormone or factor (448). This hypothesis may be true but remains unproven, as no such placental factor has been identified. WLM has presented data for an alternative hypothesis: that the perinatal transition from fetal to "adult" circulation, which increases adrenal oxygenation by a factor of 10, triggers multiple transcriptional events that lead to adrenocellular apoptosis. This oxygenation hypothesis would not exclude a contribution from withdrawal of a placental factor (449).

Adrenarche

In a 1942 paper describing 11 patients with probable Turner syndrome, Albright noted that despite evidence of absent ovarian sex steroid production, these patients had pubic and axillary hair, suggesting the adrenal secretion of androgenic hormones (450). Five years later, in a brilliantly illustrated review of the pathophysiology of osteoporosis, he introduced the term "adrenarche" (451). Albright described the roles of 3 types of steroids on bone mineralization: estrogens, androgens, and the unknown adrenal "N-hormone" (that induced nitrogen retention), which he described having "a somatotrophic action somewhat similar to the male gonadal hormone, testosterone, and the production of which in the female governs the growth of axillary and public hair and the excretion of 17KS in the urine" (ie, adrenal androgens). In outlining the timing of the various adrenal hormones, he noted: "The age of entrance of adrenal cortical 'N' hormone on the scene is termed the 'adrenarche'; the age of exit, the 'adrenopause.'" In 1943, Talbot had documented the increase in 17KS excretion beginning at about age 8 to 10 and suggested that these 17KS derive from the adrenal because there is little difference between boys and girls, but he did not identify this as a specific adrenal event (162). Urinary 17KS were increased in patients with virilizing adrenocortical carcinomas and in normal men compared to normal women and were essentially absent in women without adrenals; hence it was apparent that 17KS came from the adrenals of both sexes and, in part, represented "adrenal androgens." Many investigators studied the components of (neutral) urinary 17KS; a clear early exposition is that of Harold Mason and William Engstrom in 1950, who list 18 then-known urinary 17KS compounds (452). These authors notably state that androsterone has one-tenth the androgenic activity of testosterone, and DHEA (then termed "dehydroisoandrosterone") has one-third the androgenic activity of androsterone (they also list androstenedione but do not ascribe a level of androgenic activity to it; this androgenic activity may have been assessed by the cock's comb bioassay, but that is not stated). Thus, by 1950, DHEA was thought to be a weak androgen associated with adrenarche.

Wilkins confounded the terminology by describing children who had sexual hair before the age of 8 as having "premature pubarche"; nevertheless, he correctly concluded: "At puberty there is usually a simultaneous increase in secretion of adrenal androgens and sex hormones of the gonads. The latter are controlled by pituitary gonadotropins. It is not known what causes increased production of androgen by the adrenals at adolescence" (453). Early studies utilized large volumes of urine, but Migeon and Plager isolated DHEA from human blood, indicating it was a secreted steroid rather than a metabolite (454). Studies using isotopic dilution of radiolabeled steroids indicated that both the adrenal and testis made DHEA but that only the adrenal made DHEAS (455). By 1972 Migeon listed the so-called adrenal androgens as androstenedione, 11-oxy-androstenedione, DHEA, and DHEAS; he said: "These steroids have limited biologic activity. They can be metabolized to a small extent into potent androgens which contribute greatly to the physiologic level of androgenic activity in women but which are of little significance in men" (456). However, endocrinologists soon equated the terms "adrenal androgen" and "DHEA and DHEAS" (457), even though these steroids lacked inherent androgenic action and needed to be metabolized to active androgens in peripheral tissues (458). It would take another 40 years to identify the true human adrenal androgen as 11-keto-testosterone (see later discussion).

Studies of most endocrine phenomena are illuminated by work with animals; however, this is not the case with

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adrenarche. In 1978, Gordon Cutler and D. Lynn Loriaux reported that DHEA and DHEAS levels in the rat, guinea pig, hamster, rabbit, dog, sheep, pig, goat, horse, cow, or chicken were an order of magnitude less than human values and did not rise at the time of pubertal development. Similarly, DHEA, DHEAS, and androstenedione did not rise with age in rhesus macaques but did rise dramatically with age in chimpanzees; this rise in chimpanzees preceded the rise in gonadal sex steroids, similarly to human adrenarche (459). Thus only the chimpanzee appeared to model human adrenal C19 steroid physiology. Several subsequent studies have confirmed the proposition that only the chimpanzee (and possibly the gorilla) have an adrenarche that is similar to human adrenarche (460-462).

The question of how adrenarche might be regulated stimulated much research. Beginning in 1978, Melvin Grumbach and colleagues hypothesized the existence of a "cortical androgen stimulating hormone" (CASH), based on clinical inferences from hormonal measurements in various disease states but did no direct experimentation to test this hypothesis (463, 464). In 1979, Lawrence Parker and William Odell reported studies aimed at identifying an "adrenal androgen stimulating hormone" (AASH). Given the species specificity of adrenarche presented earlier, it is clear in retrospect that these studies would be stillborn: the source of material to be tested was bovine pituitaries (even though cattle do not have adrenarche), and the assay system was production of DHEA by castrated, dexamethasone-treated dogs (which also lack adrenarche) (465). Shortly thereafter, David C. Anderson in Salford, United Kingdom, listed several reasons to doubt the existence of such a hormone, arguing that adrenarche was solely due to intra-adrenal events (466). In 1989, Parker reported that CASH/AASH was a specific peptide derived from pro-opiomelanocortin; however, shortly thereafter 3 groups showed that Parker's peptide lacked adrenal androgen stimulating activity (467-469). Thus "AASH" and "CASH" became "MASH" —mythical androgen stimulating hormone.

Consistent with the suggestion of Anderson in 1980, more recent work supports a wholly intra-adrenal mechanism for adrenarche, including, but not limited to (i) morphologic changes within the zona reticularis (ZR); (ii) decreased expression of HSD3B2 in the ZR; and (iii) increased expression of cytochrome b5 in the ZR, thus enhancing the 17,20-lyase activity of CYP17A1 (470, 471). While these changes remain under investigation, a dramatic recent event is the identification of the principal human adrenal androgen as 11-keto-testosterone (11KT) (472). The human adrenal ZR expresses CYP11B1, which catalyzes the synthesis of 11βOH-androstenedione, which, through the sequential action of HSD11B2 and AKR1C3 (HSD17B5), produces 11KT. Both 11KT and its 5α-reduced derivative, 11KDHT, activate the androgen receptor, are higher in adrenal venous effluent than in peripheral blood, and appear to be the dominant circulating bioactive androgens in adrenarche (472, 473). Their likely roles in CAH, PCOS, and other hyperandrogenic disorders are under active investigation.

Regulation of Adrenal Development and Gene Expression

Steroidogenic Factor 1

A collaboration that led to a major advance in the understanding of adrenal gene regulation indirectly had its beginning at the first Adrenal Cortex Conference in Buffalo in 1984, when PCW was approached by Bernard Schimmer. PCW had recently cloned the *CYP21* gene encoding steroid 21-hydroxylase, which is mutated in most cases of CAH and had localized the mouse *Cyp21* genes on cosmid clones provided by Jon Seidman at Harvard (242). Schimmer suggested a collaboration to explore the regulation of this gene—and steroidogenesis in general—using mouse Y1 adrenocortical cells, which lack *Cyp21* expression (see "Adrenocortical Cell Lines and the Elucidation of Trophic Signaling Pathways"). PCW, who had a small lab at the time, referred him to Seidman who in turn assigned the project to Keith L. Parker, then a postdoctoral fellow in his laboratory.

Parker's studies demonstrated that Y1 cells stably transfected with the mouse *Cyp21* cosmid recovered hormonally regulated expression of 21-hydroxylase (474). Sequences essential for expression were localized to the proximal 330 bp of 5'-flanking DNA (475, 476). When genes encoding other steroid hydroxylases were isolated and their 5' flanking regions compared, shared AGGTCA promoter elements were identified in several of these genes that interacted with the same DNA-binding protein in steroidogenic cell lines. Parker and colleagues reasoned that the AGGTCA DNA recognition motif represented a binding site for an atypical member of the nuclear hormone receptor family and cloned mouse SF-1 cDNA from a Y1 cell cDNA library using a hybridization probe comprising the DNA-binding region of retinoid X receptor (477). Independently, Ken-ichiro Morohashi and colleagues used an oligonucleotide affinity column to purify the protein (which they termed "Ad4BP") from bovine adrenal glands, ultimately allowing them to obtain amino acid sequence and clone a bovine cDNA with an oligonucleotide probe (478). Subsequent studies established that the mouse and bovine cDNAs encoded orthologs of a protein that transactivated the steroid hydroxylase promoters in steroidogenic and nonsteroidogenic cells. The sequences of these cDNAs confirmed that SF-1 belonged to the nuclear hormone receptor family; the SF-1 gene is now officially termed *NR5A1*. Early work on SF-1 structure and function has been reviewed elsewhere (479).

Consistent with the hypothesis that SF-1 is required for adrenal and gonadal steroidogenesis, SF-1 knockout mice die shortly after birth from adrenocortical insufficiency and exhibit male-to-female sex reversal of the external genitalia. However, these abnormalities are not due to poor expression

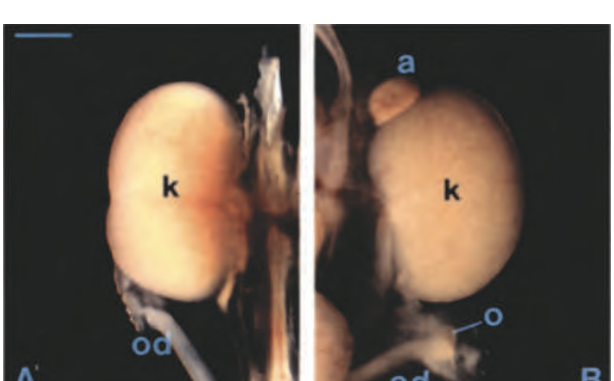

Figure 20. Newborn SF-1 (NR5A1) null mice lack adrenal glands and gonads. Abbreviations: A, SF-1 null female. B, wild-type female. k, kidney; a, adrenal; o, ovary; od, oviduct [from (480) reprinted with permission].

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of steroidogenic enzymes but instead to complete absence of the adrenal glands and gonads (Fig. 20) (480, 481). Moreover, knockout mice lack the ventromedial hypothalamic nucleus, a hypothalamic region linked to feeding and appetite regulation and female reproductive behavior (482).

In contrast to homozygous SF-1 null mice, which can be kept alive with glucocorticoid replacement, no patient has been identified who is homozygous for null mutations in the *NR5A1* gene encoding SF-1. The first 2 SF-1-defective patients identified were heterozygous for mutations that abolished the ability of SF-1 to bind DNA, thus rendering the protein transcriptionally inactive without creating a dominant negative effect. Both affected patients had adrenal insufficiency; 1 was a phenotypic female XY infant and the other was an apparently normal XX female who was not diagnosed with adrenal insufficiency until 14 months of age (483, 484). However, heterozygous SF-1 mutations subsequently were identified mainly among undervirilized 46,XY individuals (ie, XY disorders of sexual development) who do not have adrenal insufficiency (485).

Adrenal Hypoplasia Congenita and the Role of DAX1

Whereas CAH had been extensively characterized by the early 1940s, the study of adrenal hypoplasia was impeded by the lack of secretion of abnormal steroids and also by confusion between cases caused by pituitary agenesis or hypoplasia and those that were the presumed result of a primary adrenal defect. Brothers with isolated adrenal hypoplasia were reported in 1959 by Mitchell and Rhaney in Scotland (486). The first boy died at 7 weeks of age; autopsy showed adrenal hypoplasia as the only abnormality, and the authors noted an absence of normal zonation of the adrenal cortex. The younger sibling was successfully treated with fludrocortisone, sodium chloride, and cortisone acetate. Subsequent authors noted a male preponderance of such patients (487). Although adrenal hypoplasia congenita was initially thought to be an autosomal recessive condition, in 1970 Weiss and Mellinger (488) summarized data on 3 kindreds, each with at least 2 affected boys with a common mother and different fathers, strongly suggesting X-linked inheritance.

Hypogonadotropic hypogonadism occurred frequently in such patients. Moreover, patients were eventually found who had a contiguous gene syndrome consisting of adrenal hypoplasia and—in its fullest extent—glycerol kinase deficiency and Duchenne muscular dystrophy (489). These patients all had deletions in the Xp21 region, with a minimum overlapping region of 250 to 500 kb. In contrast, 46XY phenotypic female patients without adrenal insufficiency had a duplication of the same region, suggesting the presence of a dosage-sensitive sex reversal gene (490). Eventually a multinational group of investigators isolated yeast artificial chromosomes encompassing the deleted region and found a 1.6 kb fragment enriched in CpG dinucleotides, considered a marker for expressed genes. This fragment was used to screen adult testis and fetal adrenal cDNA libraries, from which a single cDNA was isolated and termed DAX-1 (DSS-AHC critical region on the X chromosome, gene 1; later termed "NR0B1") (491). The C-terminal half of the encoded protein resembled the ligand-binding domain of nuclear hormone receptors. The N-terminal half did not resemble the DNA-binding domains of other nuclear hormone receptors or any other known protein but instead contained $3^1/_2$ repeats of a 65-67 amino acid motif. DAX-1 bound DNA and functioned as a corepressor for several nuclear hormone receptors. Deletions or point mutations in DAX-1 were observed in the vast majority of patients with adrenal hypoplasia congenita, including patients who also had hypogonadotropic hypogonadism (491, 492). Subsequent work has shown that more than half of boys with adrenal hypoplasia carry DAX-1 mutations, whereas SF-1 mutations are rare (493).

Autoimmune Addison's Disease

Although Addison's first report described a patient with adrenal tuberculosis (29), his follow-up report of 11 patients included only 6 with adrenal tuberculosis; at least 1 of these, whom he showed in an illustration (Fig. 5), was of a young man with vitiligo, which is now known to be an autoimmune condition (30). Thus noninfectious forms of what we now term "Addison's disease" were known from the beginning.

Autoimmunity was identified as a major cause of Addison's disease through several parallel lines of investigation. The first was the recognition of the frequent coexistence of adrenal insufficiency and hypothyroidism without hypopituitarism, first by Schmidt (494). Autopsies of patients with Addison disease demonstrated that many had lymphocytic thyroiditis (495). Although it initially seemed possible that the thyroid disease could be a direct consequence of adrenal insufficiency, coexistent diabetes mellitus occurred in many such patients (496). These combinations of endocrinopathies—often eponymously termed Schmidt and Carpenter syndromes, respectively—are now collectively referred to as autoimmune polyglandular syndrome (APS) type 2.

Studies in the 1950s [eg, (497)] showed that lymphocytic thyroiditis was associated with the presence of autoantibodies against thyroid antigens, and both thyroid and adrenal disease could be recreated in experimental animals by injecting the respective homogenized tissue in immunogenic Freund's adjuvant [discussed in (498)]. These findings prompted a search for adrenal autoantibodies, which were indeed detected in cases of Addison disease with (499, 500) or without (500) thyroid disease. However, it was suspected that the antibodies represented a marker for a more generalized process involving cellular autoimmunity (501).

Although Schmidt and Carpenter syndromes occur with little if any familial clustering, familial cases of polyglandular endocrinopathies including Addison's disease were reported by the 1950s, often in association with hypoparathyroidism, superficial moniliasis, and occasionally pernicious anemia (500, 502, 503). Adrenal autoantibodies were detected in many of these cases. This syndrome, now termed "APS type 1," was distinct in its strong Mendelian autosomal recessive pattern of inheritance (504). It is now known to be caused by mutations in the autoimmune regulator gene [reviewed in (505)].

The most characteristic autoantigen in idiopathic Addison's disease is, in fact, the 21-hydroxylase enzyme, CYP21A2; of note, the 2 papers reporting this finding used antibodies against CYP21A2 developed in the laboratories of PCW (506) and WLM (507), respectively. In contrast, APS1 and APS2 have more diverse repertoires of autoantibodies, including those directed against 2 other steroidogenic enzymes, CYP11A1 and CYP17A1 (508, 509) [reviewed in (510)].

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Other Forms of Adrenal Insufficiency

Adrenoleudodystrophy

The history of adrenoleukodystrophy (ALD) has been reviewed by Hugo Moser (511, 512). In 1912, Paul Schilder, a Viennese psychiatrist and medical researcher who was a member of the Vienna Psychoanalytic Society founded by Sigmund Freud, described a progressive demyelinating cerebral sclerosis occurring in childhood (513). Whereas Schilder did not report symptoms of adrenal insufficiency, in 1923 Siemerling and Creutzfeldt reported a boy who had become deeply pigmented by 3 to 4 years of age and then developed behavioral alterations and progressive neurological impairment until his death at age 7 (514). The adrenal glands were atrophic. The cerebral hemispheres showed large confluent areas of demyelination associated with a perivascular inflammatory response. In 1963, Fanconi reviewed 9 cases, all of whom were male, and proposed an X-linked recessive mode of inheritance (515).

Much of the early pathological characterization was reported by Herbert Schaumburg, James Powers, and colleagues at Albert Einstein College of Medicine, who studied 9 male patients in whom Schilder's disease and adrenal pathological findings occurred together (516). They noted that "cells of the zona reticularis and fasciculata were ballooned and often contained crystalline aggregates. The X-linked recessive inheritance and this derangement of the adrenal cortex in males with Schilder's disease strongly indicate the presence of a metabolic process." The crystalline inclusions were eventually found to contain cholesterol esterified with saturated very long chain fatty acids (VLCFA) (517). The name "adrenoleukodystrophy" was in the peer-reviewed literature by 1973 (518). A breakthrough came in 1981 with the finding by Hugo Moser at Johns Hopkins' Kennedy-Krieger Institute that plasma levels of VLCFA were elevated and could be used to diagnose the disease (519). ALD is now estimated to affect approximately 1:17 000 males in the United States, similar to the frequency of CAH among males.

It was originally assumed that the defect lay in a fatty acid CoA-ligase specific for VLCFA. The ALD gene, now termed *ABCD1,* was mapped to Xq28 in 1981 (520). A putative gene was identified by positional cloning techniques in 1993 (521), with the surprising finding that it had a high degree of sequence similarity to a previously identified peroxisomal membrane protein, and not to fatty acid CoA ligases. The ALD gene product, ALDP, is a member of the ATP-binding cassette transporter family (522). Dietary treatment with a mixture of oleic and erucic acids (Lorenzo's Oil) was popularized in a film with the same name but is, in fact, of limited benefit (523).

New Forms of Adrenal Disease

The availability of modern sequencing techniques has led to the elucidation of several novel syndromes that include adrenal dysfunction. Aside from CAH and autoimmune adrenalitis, a genetic cause can now be identified in more than two-thirds of patients with primary adrenal insufficiency presenting in childhood (524). These can be grouped into several categories. We have already addressed ACTH unresponsiveness, adrenal hypoplasia congenita due to mutations in orphan nuclear hormone receptors, and defects in lipid metabolism, particularly adrenoleukodystrophy. More recently defined syndromes fall into 2 groups: those associated with intrauterine growth restriction, adrenal hypoplasia, and disorders of sexual development, such as IMAGe and MIRAGE syndromes, and deficiencies of mitochondrial reactive oxygen species detoxification.

Multisystem Syndromes Associated With Growth Restriction

MCM4 deficiency

Mutations in genes that affect DNA replication may be associated with primordial dwarfism, immune deficiency, and adrenal insufficiency. Minichromosome maintenance-deficient 4 homolog *(MCM4)* is a component of a MCM2-7 complex that is a replicative helicase essential for normal DNA replication and genome stability in all eukaryotes. As identified by whole exome sequencing, homozygous deficiency of *MCM4* causes a primary immunodeficiency syndrome (occurring with a frequency of 1 in 2506 in the Irish Traveler population) characterized by severe intra- and extrauterine growth retardation, microcephaly, decreased numbers of natural killer cells, recurrent viral infections, and adrenal insufficiency (525, 526).

MIRAGE syndrome

MIRAGE syndrome is a form of syndromic adrenal hypoplasia including myelodysplasia, infections, restriction of growth, adrenal hypoplasia, genital abnormalities, and enteropathy. It was first characterized by Narumi, Hasegawa, and colleagues at Keio University in Japan by whole-exome sequencing of 15 patients with adrenal hypoplasia but no mutations in known causative genes (527). It is caused by mutations in the sterile alpha motif domain-containing protein 9 (*SAMD9*) gene on chromosome 7q21, which encodes a protein that inhibits cell proliferation. Disease-causing mutations are heterozygous and almost invariably arise de novo. When expressed in cultured cells, the mutant proteins more strongly inhibit cell proliferation (ie, gain of function mutations). There is a risk that cells will attempt to escape growth inhibition caused by the mutant protein by selectively losing the chromosome 7 carrying the mutation, thus causing haploinsufficiency of *SAMD9*. This can cause myelodysplastic syndrome.

IMAGE syndrome

IMAGE syndrome consists of intrauterine growth retardation, metaphyseal dysplasia, adrenal hypoplasia, and genital anomalies, first characterized in 1999 by Vilain and colleagues at the University of California Los Angeles (528). Two forms have been identified. Vilain and colleagues used positional cloning to find that an autosomal dominant form was caused by mutations in the cyclin-dependent kinase inhibitor-1C (*CDKN1C*) gene (529). An autosomal recessive form was identified by whole-genome sequencing of 14 unrelated kindreds as being caused by mutations in the *POLE* gene encoding the catalytic subunit of DNA polymerase epsilon (530). Adrenal insufficiency in cases associated with *CDKN1C* mutations tends to present in early infancy, whereas in cases caused by *POLE* mutations, it is usually manifested during early childhood. The recessive form is also associated with immunodeficiency and is therefore sometimes termed "IMAGEI syndrome."

The *CDKN1C* gene product, also called p57(KIP2), binds G1 cyclin/CDK complexes and thus inhibits cell proliferation. It is located in the imprinted region of

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chromosome 11p15 and is preferentially expressed from the maternal allele. Inactivating mutations in this gene cause some cases of Beckwith-Wiedemann syndrome, which is associated with macrosomia and tumor risk. Mutations that interfere with binding of CDKN1C to DNA polymerase delta auxiliary protein enhance the growth inhibitory effect of CDKN1C (gain of function mutations) and cause IMAGE syndrome when maternally inherited.

Deficiency of Mitochondrial Reactive Oxygen Species Detoxification

Nicotinamide nucleotide transhydrogenase (*NNT*) is a mitochondrial protein that catalyzes transfer of a hydride ion from nicotinamide adenine dinucleotide, NADH, to oxidized nicotinamide dinucleotide phosphate, $NADP^+$. Its deficiency generally occurs in infancy or early childhood, and most patients have both mineralocorticoid and glucocorticoid deficiencies (531). A mutation in *TXNRD2*, encoding a mitochondrial selenoprotein, thioredoxin reductase 2, was identified by whole-exome sequencing of a single consanguineous Pakistani kindred with glucocorticoid deficiency (532). This protein, not to be confused with adrenodoxin (or ferredoxin) reductase, helps maintain mitochondrial redox homeostasis; inactivating it in cultured cells decreases the oxidized to reduced glutathione ratio and increases levels of mitochondrial reactive oxygen species.

Conclusion

A recurring theme in this review is how the history of adrenal research parallels the broader history of biomedical discovery. We expect that to continue. WLM has discussed a series of unanswered questions in steroidogenesis (especially adrenal steroidogenesis) (533), including the elusive roles of the fetal adrenal and of DHEA/DHEAS; these are not reiterated here. Considering some more recent advances that have not yet affected adrenal research suggests we may see some of the following in the future.

First, the 21st-century discoveries of many new deficiency diseases suggests that there are still other adrenal diseases to be discovered. A prime candidate is the mitochondrial flavoprotein, ferredoxin reductase (FdxR) (also known as adrenodoxin reductase). Mitochondrial forms of cytochrome P450, such as the cholesterol side-chain cleavage enzyme (CYP11A1), 11-hydroxylase (CYP11B1), and aldosterone synthase (CYP11B2) must receive electrons from NADPH via the intermediacy of FdxR and ferredoxin (Fdx), an iron-sulfur protein. Both Fdx and FdxR also participate in the biosynthesis of iron-sulfur clusters; defects in this process are associated with Friedrich's ataxia and with Parkinson disease. Beginning in 2017, mutations in FdxR have been reported in 45 patients (in 33 families) with optic atrophy, neuropathic hearing loss, developmental delay, and other neurodevelopmental problems, reflecting a global mitochondrial disorder (534-539). Studies of potential disorders in steroidogenesis have not yet been reported, nor have human genetic disorders of Fdx been reported. One of us (WLM) has reviewed this topic, speculating that FdxR patients will have mild defects in steroidogenesis analogous to patients with nonclassic forms of lipoid CAH or CYP11A1 deficiency (540).

Second, whereas genetic studies of adrenal diseases in the 20th century concentrated on forms of CAH, the recurrent theme in the 21st century is on diseases that cause cell death by affecting DNA replication and repair (IMAGE types 1 and 2, MCM4 deficiency), impairing the ability to withstand oxidative stress (NNT and TXNRD2 deficiencies and perhaps Allgrove syndrome) and inhibiting cell proliferation (MIRAGE syndrome). Whereas these syndromes variously affect many other physiologic processes, it remains unclear why primary adrenal insufficiency is a consequence of all of them. Further insights into the unique metabolic vulnerabilities of the adrenal cortex would be of great interest.

Third, it is already apparent that some disorders not generally regarded as adrenal disorders do, in fact, involve the adrenal; the prime example of this is PCOS, in which there is hyperandrogenism of both ovarian and adrenal origin (541). Whether this logical link between the adrenal and ovary also applies to testicular disorders remains unclear.

Fourth, contemporary advances in gene therapy and gene editing offer promise for eventual improved treatment or even cure for genetic disorders of steroidogenesis. Nevertheless, as hormonal replacement therapy is so effective, we believe that such technologies will be appropriate for CAH and other adrenal disorders only after they have been proven safe and effective in many other, more lethal disorders. Among adrenal disease, the first candidate should certainly be adrenoleukodystrophy because of its devastating neurological consequences, and indeed, such therapy is in an advanced stage of development (542).

Fifth, newer molecular imaging technologies, notably cryoelectron microscopy, are revolutionizing the ability to image both individual macromolecules and larger macromolecular motors. Complex steroidogenic actions such as interactions of StAR with multiple mitochondrial proteins may be amenable to this approach, perhaps eventually revealing how StAR works.

Finally, we close with a reminder from the great American philosopher Yogi Berra: "It's tough to make predictions; especially about the future."

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Androgenüberproduktion (adrenaler Pseudohermaphroditismus masculinus) [The syndrome of male pseudohermaphrodism in congenital adrenocortical hyperplasia without overproduction of androgens (adrenal male pseudohermaphrodism)]. *Helv Paediatr Acta* 1955;10(4):397-412.
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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, December 02, 2022 3:15 PM PST
To: [redacted]@gmail.com>; [redacted]>
Subject: Re: REMINDER: Endocrine Grand Rounds 12/7/2022

Hi [redacted],
I'm don't know the presenter, but the topics are legit. In fact, there's a chapter on eunuchs in the recently released Standards of Care 8 from WPATH. I'll also send you a rebuttal to the recent NYT article.
Best wishes,
Steve Rosenthal

Get Outlook for iOS

From: [redacted]@gmail.com>
Sent: Friday, December 2, 2022 3:31:59 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@yahoo.com>
Subject: Fwd: FW: REMINDER: Endocrine Grand Rounds 12/7/2022

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You have not previously corresponded with this sender.

Hi Stephen,
My cousin, [redacted], who you may know from your [redacted] days, sent me the email below. Do you know if this is legit or quackery? I ask only because the NYT and other places have seemingly been sliding into disseminating misleading information and given the title of this seminar, was not sure if it was legit or not.
Thanks
[redacted]

---------- Forwarded message ---------
From: [redacted]@delmarinc.com>
Date: Fri, Dec 2, 2022 at 1:46 PM
Subject: FW: REMINDER: Endocrine Grand Rounds 12/7/2022
To: [redacted]@gmail.com <[redacted]@gmail.com>

Maybe of interest.

Love,

[redacted]

From: Williamson, Amanda <aswilliamson@health.ucsd.edu>
Sent: Friday, December 2, 2022 9:31 AM
Cc: Arce-Gastelum, Alheli <aarcegastelum@health.ucsd.edu>
Subject: REMINDER: Endocrine Grand Rounds 12/7/2022

University of California, San Diego

Division of Endocrinology

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GRAND ROUNDS

9:30 am -10:30 am

ZOOM – see details below

Wednesday,December 7, 2022

Transgender medicine, important neglected topics - nonbinary, detransition and eunuchs

[redacted], MD

2nd Year Fellow

University of California, San Diego

ZOOM INFO:

Join from PC, Mac, Linux, iOS or Android [redacted]

Password: [redacted]

Or iPhone one-tap :

US: [redacted] Or Telephone:

Dial(for higher quality, dial a number based on your current location):

US: [redacted]

Meeting ID: [redacted]

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From: [redacted]@scdi.org.vn>
Sent: Monday, December 05, 2022 2:24 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>; [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

This Message Is From an External Sender
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Dear Steve,
This time is appropriate for the team and also for me (at Vietnam time).
Thank you so much for kind support. I will send the zoom link later.
Warm regards,

[redacted]

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[redacted] (Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
SCDI | Số 9 ngách 30 ngõ 165 Thái Hà, P.Láng Hạ, Q.Đống Đa | Hanoi | Vietnam
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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, December 1, 2022 8:41 AM
To: [redacted]@scdi.org.vn>; [redacted], [redacted] <[redacted]@ucsf.edu>; [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

Hi [redacted],

How about January 9 from 7:00-9:00 PM? It looks like this might work for [redacted]. It would be wonderful if this also works for [redacted]

Thanks and best wishes,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@scdi.org.vn>
Sent: Sunday, November 27, 2022 7:41 PM
To: [redacted], [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

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sender.

Dear Dr. Stephen, Dr. [redacted] and Dr. [redacted]
Thank you very much for your kind support. Because of the visa submission requirement so all the team members have booked their round-trip flight (from Hanoi to LA and back) before I received your email. And I also understand that the pandemic situation is still serious in U.S. Therefore, could I suggest we have a zoom meeting in about 2 hours with Vietnam team member during their time in LA? if it is appropriate, I will share with you our detail agenda for this trip so we can arrange this meeting.

Thank you and warm regards,

[redacted]

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[redacted] (Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
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From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 28, 2022 3:31 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@scdi.org.vn>
Cc: [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

I would love to be able to meet, but I'm on vacation and away January 1st through 8th. I will be back on the 9th, but that may be too late for a visit since [redacted] you all be completing your U.S. visit on January 11th.

Best,
[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 24, 2022 11:09 AM
To: [redacted]@scdi.org.vn>
Cc: [redacted] <[redacted]@ucsf.edu>; [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

Dear [redacted],

It's very nice to hear from you! I apologize for my delayed response—just a very busy time. I would be able to meet with you during the day on Tuesday, January 3rd, starting at 1 PM. Our full Child and Adolescent Gender Center team is not currently meeting in person because of the pandemic, but rather by telehealth. However, I have cc'd my colleague, Dr. [redacted], whom you met in Hanoi, who may also be available to meet on the afternoon of January 3rd. Please let me know if January 3rd at 1 PM works for you, and i can send you details of where we can meet. I have also cc'd Dr. [redacted], in the event that she is also able to meet at that time.

Best wishes,

Sincerely,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

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Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
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Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@scdi.org.vn>
Sent: Tuesday, November 15, 2022 6:30 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: SCDI - Visit trip for services providers and policy makers from Vietnam

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Dear Dr. Stephen,
I hope this email finds you well. I am writing to you to share that we are currently arranging a visit trip for a team of 5 people: 1 surgeon, 1 endocrinologist, 1 psychologist, 1 SCDI officer and 1 person on the drafting team to Los Angeles to visit Dr. [redacted] hospital, community people and policy makers there to learn about the cooperate between 3 services for transgender people. As you may know that we are advocating for the drafted law on gender affirmation and under the drafted law, the Ministry of Health need to develop 2 guidelines on surgery and psychological support but the drafting team don't have any ideas for this. They have learnt from other countries via documents we and our partners provided for them. We expect with this trip, they will have the opportunity to better understand this coordination as well as the support needed for transgender people. I know Los Angeles is a very good practice to learn but I wonder if we have time, may we visit you, your hospital and meeting with community organization, policy makers (if applicable) in San Francisco. The team will be in U.S from 2 - 11 January 2023 and we can have 3 days in San Francisco.
Thank you very much and I am looking forward to hearing from you.

Warm regards,

[redacted]

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[redacted] (Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
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From: [redacted]@gmail.com>
Sent: Monday, December 05, 2022 6:50 AM PST
To: [redacted]@scdi.org.vn>
CC: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

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This time works for me. Thanks and I'm looking forward to it.
Best,
[redacted]

Sent from my iPhone

On Dec 5, 2022, at 02:24, [redacted]@scdi.org.vn> wrote:

Dear Steve,
This time is appropriate for the team and also for me (at Vietnam time).
Thank you so much for kind support. I will send the zoom link later.
Warm regards,

[redacted]

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[redacted] (Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
SCDI | Số 9 ngách 30 ngõ 165 Thái Hà, P.Láng Hạ, Q.Đống Đa | Hanoi | Vietnam
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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, December 1, 2022 8:41 AM
To: [redacted]@scdi.org.vn>; [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>; [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

Hi [redacted],

How about January 9 from 7:00-9:00 PM? It looks like this might work for [redacted]. It would be wonderful if this also works for [redacted].

Thanks and best wishes,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@scdi.org.vn>
Sent: Sunday, November 27, 2022 7:41 PM
To: [redacted], [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

This Message Is From an Untrusted Sender
You have not previously corresponded with this sender.

Dear Dr. Stephen, Dr. [redacted] and Dr. [redacted],
Thank you very much for your kind support. Because of the visa submission requirement so all the team members have booked their round-trip flight (from Hanoi to LA and back) before I received your email. And I also understand that the pandemic situation is still serious in U.S. Therefore, could I suggest we have a zoom meeting in about 2 hours with Vietnam team member during their time in LA? if it is appropriate, I will share with you our detail agenda for this trip so we can arrange this meeting.

Thank you and warm regards,

[redacted]

<Outlook-1496240420.png>

[redacted](Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
SCDI | Số 9 ngách 30 ngõ 165 Thái Hà, P.Láng Hạ, Q.Đống Đa | Hanoi | Vietnam
T +84 (0)24 3572 0679 (số máy lẻ: 161) | F +84 (0)4 3572 0689 | M [redacted]
www.scdi.org.vn | www.facebook.com/scdivietnam | https://www.youtube.com/SCDIVietnam
One ream (500 sheets) of paper is equivalent to 5% of a tree. Please consider the trees before printing this email.

From: [redacted], [redacted] <[redacted]@ucsf.edu>
Sent: Monday, November 28, 2022 3:31 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@scdi.org.vn>
Cc: [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

I would love to be able to meet, but I'm on vacation and away January 1st through 8th. I will be back on the 9th, but that may be too late for a visit since [redacted], you all be completing your U.S. visit on January 11th.

Best,
[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 24, 2022 11:09 AM
To: [redacted]@scdi.org.vn>
Cc: [redacted], [redacted] <[redacted]@ucsf.edu>; [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

Dear [redacted],

It's very nice to hear from you! I apologize for my delayed response—just a very busy time. I would be able to meet with you during the day on Tuesday, January 3rd, starting at 1 PM. Our full Child and Adolescent Gender Center team is not currently meeting in person because of the pandemic, but rather by telehealth. However, I have cc'd my colleague, Dr. [redacted], whom you met in Hanoi, who may also be available to meet on the afternoon of January 3rd. Please let me know if January 3rd at 1 PM works for you, and i can send you details of where we can meet. I have also cc'd Dr. [redacted] in the event that she is also able to meet at that time.

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Best wishes,

Sincerely,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
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Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@scdi.org.vn>
Sent: Tuesday, November 15, 2022 6:30 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: SCDI - Visit trip for services providers and policy makers from Vietnam

This Message Is From an External Sender
This message came from outside your organization.

Dear Dr. Stephen,
I hope this email finds you well. I am writing to you to share that we are currently arranging a visit trip for a team of 5 people: 1 surgeon, 1 endocrinologist, 1 psychologist, 1 SCDI officer and 1 person on the drafting team to Los Angeles to visit Dr. [redacted]hospital, community people and policy makers there to learn about the cooperate between 3 services for transgender people. As you may know that we are advocating for the drafted law on gender affirmation and under the drafted law, the Ministry of Health need to develop 2 guidelines on surgery and psychological support but the drafting team don't have any ideas for this. They have learnt from other countries via documents we and our partners provided for them. We expect with this trip, they will have the opportunity to better understand this coordination as well as the support needed for transgender people. I know Los Angeles is a very good practice to learn but I wonder if we have time, may we visit you, your hospital and meeting with community organization, policy makers (if applicable) in San Francisco. The team will be in U.S from 2 - 11 January 2023 and we can have 3 days in San Francisco.
Thank you very much and I am looking forward to hearing from you.

Warm regards,

[redacted]

<Outlook-1496240420.png>

[redacted] (Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
SCDI | Số 9 ngách 30 ngõ 165 Thái Hà, P.Láng Hạ, Q.Đống Đa | Hanoi | Vietnam
T +84 (0)24 3572 0679 (số máy lẻ: 161) | F +84 (0)4 3572 0689 | M [redacted]
www.scdi.org.vn | www.facebook.com/scdivietnam | https://www.youtube.com/SCDIVietnam
One ream (500 sheets) of paper is equivalent to 5% of a tree. Please consider the trees before printing this email.

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, December 05, 2022 7:21 AM PST
To: [redacted]@gmail.com>; [redacted]@scdi.org.vn>
CC: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

And for me as well. And looking forward to it.

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: [redacted]@gmail.com>
Sent: Monday, December 5, 2022 6:50 AM
To: [redacted]@scdi.org.vn>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

This Message Is From an External Sender
This message came from outside your organization.

This time works for me. Thanks and I'm looking forward to it.
Best,
[redacted]

Sent from my iPhone

On Dec 5, 2022, at 02:24, [redacted]@scdi.org.vn> wrote:

Dear Steve,
This time is appropriate for the team and also for me (at Vietnam time).
Thank you so much for kind support. I will send the zoom link later.
Warm regards,

[redacted]

<Outlook-1496240420.png>

[redacted] (Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program
Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, December 1, 2022 8:41 AM
To: [redacted]@scdi.org.vn>; [redacted] <[redacted]@ucsf.edu>; [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

Hi [redacted]

How about January 9 from 7:00-9:00 PM? It looks like this might work for [redacted]. It would be wonderful if this also works for [redacted].

Thanks and best wishes,

Steve

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
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Tel.: (415) 476-2266
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email: Stephen.Rosenthal@ucsf.edu

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Sent: Sunday, November 27, 2022 7:41 PM
To: [redacted], [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@gmail.com>
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To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@scdi.org.vn>
Cc: [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

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Best,
[redacted]

[redacted] [redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted].[redacted]@ucsf.edu

Obtained via CPRA by Judicial Watch, Inc.

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, November 24, 2022 11:09 AM
To: [redacted]@scdi.org.vn>
Cc: [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>; [redacted]@gmail.com>
Subject: Re: SCDI - Visit trip for services providers and policy makers from Vietnam

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Sincerely,

Steve

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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@scdi.org.vn>
Sent: Tuesday, November 15, 2022 6:30 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: SCDI - Visit trip for services providers and policy makers from Vietnam

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Warm regards,

[redacted]

<Outlook-1496240420.png>

[redacted](Ms, She, Her), MA
Quản lý Chương trình Hỗ trợ Cộng đồng | Program Manager of Community Support Program

Obtained via CPRA by Judicial Watch, Inc.

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Trung tâm Hỗ trợ Sáng kiến Phát triển Cộng đồng | Centre for Supporting Community Development Initiatives
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From: [redacted], MD, MPH <updates@email.liebertpub.com>
Sent: Monday, December 05, 2022 11:01 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: From the Editor's Desk

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[redacted] Ann Liebert, Inc.

Announcement

Transgender Health

A Letter from the Editor

Dear Colleagues,

It has been an outstanding year for ***Transgender Health***, and I would like to take this opportunity to thank our many dedicated contributors whose hard work, expertise, and advocacy have been instrumental in building the journal as well as developing and defining this discipline. *Transgender Health* received its first Impact Factor of **4.427** this year – a tremendous achievement that establishes the journal as a leading publication in the field. Full-text article downloads have also increased by 15% year-to-date and we have made substantial progress in assembling a diverse editorial board.

In early 2022, we published our first Special Issue on Telehealth for Gender-Affirming Care, guest edited by Nadia Dowshen, MD, MSHP. Articles in this timely issue highlight opportunities, innovations, and challenges related to the delivery of gender-affirming care via telehealth services. Other recent articles of notable interest and impact have examined the effects of gender-affirming hormone therapy on body satisfaction, self-esteem, quality of life, and psychopathology and explored the complex relationship that transgender and nonbinary adolescents and young adults have with their body, eating, and exercise. An important literature review summarized the research on affirming and inclusive care training for medical students and residents while another study identified factors associated with depression and quality of life among transgender women with experiences of bullying.

As the field evolves, we aim to cover new and emerging developments with emphasis on high-quality original research articles and reviews in key areas relevant to the health and wellbeing of transgender and gender diverse people, communities, and populations. These include: access to primary and gender-affirming healthcare; the cancer care continuum; outcomes related to health equity; sexual and reproductive health, including fertility preservation; international perspectives; gynecologic and urologic care; gender-affirming models of care and health outcomes; gender minority stress, mental health and substance use; transgender specific health-related measures and measure development; social support, community connection and resilience; viral suppression, PrEP uptake and outcomes across the HIV care continuum; and ethical considerations in consent and other aspects of gender-affirming care. We also welcome perspective articles that provide scholarly insights and opinions on the Standards of Care for the Health of Transgender and Gender Diverse People, Version 8.

Transgender Health is dedicated exclusively to addressing the specific healthcare needs of transgender and gender diverse individuals across their lifespan, filling gaps in scientific knowledge, and identifying priority areas where research, policy and clinical practice development, and education are needed to achieve healthcare equity. We also continue to welcome your general manuscript submissions for rapid and transparent peer review and encourage you to recommend the Journal to your library or institution to facilitate access to authoritative, multidisciplinary content that addresses a broad range of scientific, medical, and psychosocial issues in transgender healthcare and research.

The mission of this journal is of vital importance, and I am grateful for your partnership in this endeavor.

Sincerely,
[redacted] **Garofalo, MD, MPH**
Editor-in-Chief

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

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140 Huguenot Street, 3rd Floor, New Rochelle, NY, 10801-5215, USA

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You have received this email at Stephen.Rosenthal@ucsf.edu.
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add updates@email.liebertpub.com to your Address Book or Safe Senders List.

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, December 07, 2022 3:08 PM PST
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: Secure: touching base

Thanks, [redacted], from me as well.

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Wednesday, December 7, 2022 2:54 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; Rosenthal, Stephen
<Stephen.Rosenthal@ucsf.edu>
Subject: Re: Secure: touching base

Thanks, [redacted].

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Wednesday, December 7, 2022 1:51 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; Rosenthal, Stephen
<Stephen.Rosenthal@ucsf.edu>
Subject: Secure: touching base

Hallo team:

Just so you're in the know, I've reached out to each therapist about updates to their letters (each one missed a piece that is required for approval), just waiting to hear back in case families ask

Best,
[redacted]

[redacted], MD, MS
Assistant Professor, Division of Child & Adolescent Psychiatry
University of California, San Francisco - Pritzker
Zuckerberg San Francisco General Hospital
Pronouns: *he/him/his, they/them/theirs*
Twitter|LinkedIn|UCSF Profile

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, December 07, 2022 4:24 PM PST
To: [redacted] <[redacted]@ucsf.edu>
Subject: Re: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

Just did it!
[redacted]
Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, December 7, 2022 12:40 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Fw: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

Hi, Steve,

We need to fill this out. I missed this e-mail earlier.

xo,
[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: noreply@salesforce.com <noreply@salesforce.com> on behalf of [redacted]@ucsf.edu>
Sent: Monday, November 21, 2022 4:23 PM
To: [redacted] <[redacted]@ucsf.edu>
Subject: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

This Message Is From an External Sender
This message came from outside your organization.

Dear Dr. [redacted],

You are receiving this email because you have been listed as an "investigator" for the above referenced award. Per Public Health Service (PHS) regulations, you are required to update your COI-SMART financial disclosure annually and within 30 days of a new financial interest/relationship.

NOTE: THE DISCLOSURE REQUIREMENT INCLUDES (but is not limited to):
**ANY equity interests (i.e., shares, options, warrants even if valued at $0)
**One-time payments (if relationship with entity has not been reported in the previous 12 months)
**ANY payments received from a foreign entity, including foreign institutions of higher education or the government of a foreign country.

COI-SMART--INSTRUCTIONS TO UPDATE:
1. Please login to COI-Smart via My Access.
2. Click on the "Submitted" link for your Main Questionnaire 3.0 under "My Questionnaires" to display the disclosure

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questions.
3a. WITH UPDATES/CHANGES TO DISCLOSURE: Click Revise and update each question to reflect updated financial disclosures and outside activity for the previous 12 months accordingly. After updates have been made, continue to step #4.
3b. WITH NO CHANGES TO DISCLOSURE: Click one of the Revise buttons and continue to step #4.
4. At the very bottom of the page click CONTINUE TO SUBMISSION REVISION page.
5. A popup window will display and will prompt you to type the word “REVISE” and submit your updated disclosure .

You will receive an automated e-mail from COI-Smart if you have submitted your revision/update correctly. Once you complete your disclosures, if you notify COI at COIAC@ucsf.edu, we can prioritize the review and release of your project.

ETHICS AND COMPLIANCE BRIEFING FOR RESEARCHERS (ECBR) TRAINING
Researchers are required to complete training every two years. “Ethics and Compliance Briefing for Researchers” (ECBR) is the current module (effective 11/15/2021) that fulfills PHS and University of California training requirements, and replaces the “Conflict of Interest for Researchers” (COIR) module. If you started the older COIR module, you must complete the training by 12/31/2021 or your progress will be lost and you will need to complete the ECBR module.

1. You may fulfill your training requirement or verify your completion by logging onto the Learning Management System: https://learningcenter.ucsfmedicalcenter.org/

2. Search for "ECBR" to locate the Ethics and Compliance Briefing for Researchers.

3. If you have already taken the ECBR or COIR training within the previous two years, your requirement has been fulfilled. Training must be current in order to access extramural funds.

INFORMATION REGARDING DISCLOSURES OF OUTSIDE ACTIVITIES AND INDUSTRY PAYMENTS:
**The COI-Smart financial disclosure is used for financial conflict of interest in research, which is separate and distinct from Outside Activities reporting done via the OATS System through a faculty member's department/Academic Affairs. You can access the OATS system through MyAccess, and review guidance here: https://academicaffairs.ucsf.edu/oats/

**Physicians are encouraged to check externally reported sources of payments from industry, such as OpenPayments.com, and work with their department to correct or retract incorrect entries posted on the Open Payments website. Review guidance here: https://compliance.ucsf.edu/open-paymentssunshine-act

**If you identify any personal financial interests in the OATS System or in Open Payments that should also be reported in the COI-Smart system, please update your COI disclosure as soon as possible.

Thank You,
Conflict of Interest Team at UCSF

Obtained via CPRA by Judicial Watch, Inc.

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Subject: Re: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, December 7, 2022 4:24 PM
To: [redacted] <[redacted]@ucsf.edu>
Subject: Re: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

Just did it!
[redacted]
Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, December 7, 2022 12:40 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Fw: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

Hi, Steve,

We need to fill this out. I missed this e-mail earlier.

xo,
[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: noreply@salesforce.com <noreply@salesforce.com> on behalf of [redacted]@ucsf.edu>
Sent: Monday, November 21, 2022 4:23 PM
To: [redacted] <[redacted]@ucsf.edu>
Subject: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

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Dear Dr. [redacted],

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3b. WITH NO CHANGES TO DISCLOSURE: Click one of the Revise buttons and continue to step #4.
4. At the very bottom of the page click CONTINUE TO SUBMISSION REVISION page.
5. A popup window will display and will prompt you to type the word “REVISE” and submit your updated disclosure .

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ETHICS AND COMPLIANCE BRIEFING FOR RESEARCHERS (ECBR) TRAINING
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INFORMATION REGARDING DISCLOSURES OF OUTSIDE ACTIVITIES AND INDUSTRY PAYMENTS:
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Thank You,
Conflict of Interest Team at UCSF

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, December 07, 2022 8:36 PM PST
To: [redacted] <[redacted]@ucsf.edu>
Subject: Re: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

[redacted]

XO,
Steve

Get Outlook for iOS

From: [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, December 7, 2022 8:01:02 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, December 7, 2022 4:24 PM
To: [redacted] <[redacted]@ucsf.edu>
Subject: Re: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

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[redacted]
Steve

Stephen M. Rosenthal, M.D.
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, December 7, 2022 12:40 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Fw: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

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xo,
[redacted]

[redacted], Ph.D.

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Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: noreply@salesforce.com <noreply@salesforce.com> on behalf of [redacted]@ucsf.edu>
Sent: Monday, November 21, 2022 4:23 PM
To: [redacted] <[redacted]@ucsf.edu>
Subject: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

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Thank You,
Conflict of Interest Team at UCSF

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, December 08, 2022 7:37 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

[redacted]

xo,
[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, December 7, 2022 8:36 PM
To: [redacted] <[redacted]@ucsf.edu>
Subject: Re: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

[redacted]
XO,
Steve

Get Outlook for iOS

From: [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, December 7, 2022 8:01:02 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, December 7, 2022 4:24 PM
To: [redacted] <[redacted]@ucsf.edu>
Subject: Re: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

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Steve

Stephen M. Rosenthal, M.D.
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email: Stephen.Rosenthal@ucsf.edu

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Sent: Wednesday, December 7, 2022 12:40 PM
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Subject: Fw: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

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e-mail: [redacted]@ucsf.edu

From: noreply@salesforce.com <noreply@salesforce.com> on behalf of [redacted]@ucsf.edu>
Sent: Monday, November 21, 2022 4:23 PM
To: [redacted] <[redacted]@ucsf.edu>
Subject: COI DISCLOSURE REQUEST, Study PI: [redacted], CA-0211090

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From: Rosenthal, Stephen
Sent: Tuesday, December 13, 2022 8:27 AM PST
To: [redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>
Subject: Meeting request

Hi [redacted]

I hope you are doing well! I'd like to set up a time to meet with you (in person or zoom) sometime in the next few weeks (January is fine!) to discuss my plans for the coming academic year.

Thanks and best wishes,

Steve

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email: Stephen.Rosenthal@ucsf.edu

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From: [redacted]@ucsf.edu>
Sent: Tuesday, December 13, 2022 10:44 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Meeting request

Hi Steve,

Please confirm if you can meet with [redacted] on these dates/times:

Mon 1/9: 10:00 AM – 12:00 PM – In person or Zoom
Tues 1/10: 10:00 AM – 11:00 PM – Zoom
Wed 1/11: 2:30 PM – 4:00 PM – Zoom
Thurs 1/12: 10:00 AM – 11:00 AM – Zoom
Fri 1/13: 12:00 PM – 2:00 PM – Zoom
Wed 1/18: 1:00 PM – 4:00 PM – Zoom
Mon 1/23: 10:00 AM – 11:00 AM – In person or Zoom
Wed 1/25: 1:00 PM – 4:00 PM – Zoom
Mon 1/30: 10:00 AM – 12:00 PM – In person or Zoom

Thank you and Happy Holidays!
[redacted]

Out of office: 12/15/22 - 1/2/23

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, December 13, 2022 8:27 AM
To: [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Meeting request

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Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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From: [redacted]@ucsf.edu>
Sent: Tuesday, December 13, 2022 10:55 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Meeting request

Great! Happy to.

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Date: Tuesday, December 13, 2022 at 8:27 AM
To: [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Meeting request

Hi [redacted],

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, December 13, 2022 11:30 AM PST
To: [redacted] <[redacted]@ucsf.edu>
Subject: Re: Summer internship

Hi [redacted],

I know that for a medical trainee, UCSF is not (because of Covid) currently accepting individuals from other countries--I recently had an inquiry from Chile. Arrangements can be made for participation of trainees by zoom at least for the pre-clinic conference, and potentially ([redacted] would know) during actual patient interactions. Not clear if the trainee you mentioned is medical or mental health.

XO,

Steve

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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, December 13, 2022 11:18 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Summer internship

Hi Steve,

Welcome back. So a question. A student from University of Hamburg, [redacted] who had an internship at the Gender Center at Careggi Hospital in Florence reached out to me and would like to come do an internship at our program for three months starting this summer, learning about what we do at the clinic and possibly helping out in any of our research studies. She sounds interesting, and I can certainly check with [redacted] who [redacted] followed at the Gender Center, to find out more about her. Do you think we have any bandwidth to do this?

xo,
[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
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1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

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From: Rosenthal, Stephen
Sent: Tuesday, December 13, 2022 6:24 PM PST
To: [redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>
Subject: January CAGC Staff mtg

Hi [redacted]

Please note that our January CAGC Staff mtg will be January 17 instead of January 24.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
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email: Stephen.Rosenthal@ucsf.edu

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From: [redacted]@ucsf.edu>
Sent: Wednesday, December 14, 2022 8:29 AM PST
To: [redacted]@ucsf.edu>
Subject: Match details, grand rounds on hold over holidays and holiday wishes

Dear All,

As I mentioned in my message from a couple of weeks ago, we had a successful match for our fellowship programs, and I have posted the names of people who matched to our programs below. I want to reiterate my gratitude to all the faculty, staff and trainees who participated in the recruitment efforts, I know it is a lot of work! I am also including a list of all our residents at both sides of the Bay who are going into fellowships here and elsewhere with a heartfelt congratulations to all!

And just a reminder that this week's grand rounds speaker had to cancel, and there will be no grand rounds next week or the week after because of the holidays. We will be back on January 5 with a session on RSV, details to be posted soon on http://tiny.ucsf.edu/pediatricgrandrounds

Lastly, as we are getting closer to the holidays while still dealing with a surge in respiratory diseases, I want to give a big shout out to everyone who is working hard to take care of all our patients. Many people are working extra shifts and longer hours, not only to cover the additional patients and deal with high turnover, but also to cover for colleagues who deal with illness themselves. I realize that this is taking a toll on everyone, but want to give special recognition to the trainees who at baseline already work many long hours. It sometimes may seem to go unnoticed what a crucial role they play, so let's all take a moment to show some appreciation for all their hard work.

Hope everyone has a chance to decompress for a little bit over the holidays, and try to stay healthy!

[redacted]

[redacted], MD PhD
Professor of Pediatrics
Baum Family Presidential Chair for Experiential Learning
Vice-Chair for Education, Department of Pediatrics

MATCH BY FELLOWSHIP

Adolescent Medicine:
[redacted] MD — University of Washington
[redacted] MD — Dartmouth University

Allergy Immunology:
[redacted] MD — Kaiser Permanente San Francisco
[redacted] MD — Children's Hospital of Los Angeles

BMT:
[redacted] MD — UCSF

Cardiology:
[redacted] MD — UCSF Fresno
[redacted] MD — BCH-OAK
[redacted] MD — Tucson Medical Center

Critical Care:
[redacted] MD — UCSF BCH Oakland
[redacted] MD — Christiana Care/Nemours Children's Hospital
[redacted] MD — University of North Carolina at Chapel Hill
[redacted] MD — Yale New Haven Hospital

Emergency Medicine
[redacted] MD — University of Chicago Pediatrics
[redacted] MD, MPH — Children's National, Washington DC

Endocrinology:
[redacted] MD — UCSF BCH Oakland
[redacted] MD — Tufts Children's Hospital

Gastroenterology:
[redacted] MBBCh — Michigan St. Univ-East Landsing
[redacted] MD — UCSF
[redacted] MD — U Wisconsin Hospital and Clinics

Hematology Oncology (UCSF- Mission Bay Program):
[redacted] DO — Wright State University

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[redacted] MD UCSF
[redacted] MD Medical College of Wisconsin

Hematology Oncology (UCSF BCH Oakland Program):
[redacted] MD - University of Florida, Pensacola
[redacted] MD - Harbor-UCLA Medical Center

Hospital Medicine
[redacted] MD Stanford University
[redacted] DO University of Arizona

Infectious Diseases
[redacted] MD UCSf BCH Oakland
[redacted] MD CHOP
[redacted] MD Baystate Springfield

Medical Genetics
[redacted] MD Brookdale University Hospital and Medical Center

Neonatology
[redacted] MD UCSF
[redacted] MD UCLA
[redacted] MD UCSF

Nephrology:
[redacted] MD Nicklaus Children's Hospital – Miami

Pulmonary:
[redacted] MD Maimonides Children's Hospital

Rheumatology :
[redacted] MD Montefiore Med Ctr/Einstein- NY

Transplant Hepatology
[redacted] MD UCSF

WHERE OUR RESIDENTS MATCHED

UCSF Mission Bay Program

[redacted] Cardiology, Children's Hospital of Michigan
[redacted] Cardiology, NYP Hospital-Columbia Univ Med
[redacted] – Neonatology, UCSF
[redacted] Pediatric Pulmonology, UCSD
[redacted] Pediatric GGastroenterology, UCSF
[redacted] Pediatric Critical Care, University of Minnesota
[redacted] – Pediatric Critical Care, Stanford
[redacted] Pediatric Gastroenterology, CHLA
[redacted] Hematology-Oncology, UCSF (Mission Bay)
[redacted]

UCSF BCH Oakland Program

[redacted] Pediatric Cardiology, UCSF
[redacted] – Pediatric Hematology-Oncology, Stanford
[redacted] – General Academic Pediatrics, CHLA
[redacted] – Pediatric Gastroenterology, CHLA
[redacted] Pediatric Critical Care, Cornell
[redacted] Pediatric Infectious Disease, UCSF
[redacted] – Pediatric Endocrinology, UCSF
[redacted] – Palliative Care, St. Judes
[redacted] – Pediatric Critical Care, UCSF

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Friday, December 16, 2022 4:04 PM PST
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
[redacted]@ucsf.edu>
Subject: Re: CAGC SW

I don't have a link either. Please send.

[redacted], Ph.D,
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Wednesday, November 30, 2022 12:09 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi team,

Since our schedules all have a tendency to fill up, I'll go ahead and send a meeting invite to you all for 12/16 at 3pm

Please accept the meeting if you're able to make it! Thank you!

[redacted] LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Tuesday, November 29, 2022 10:57 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: CAGC SW

I would be available 3 pm to 5:30 pm on 12/16.

[redacted], Ph.D,
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 29, 2022 10:16 AM
To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>

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Subject: Re: CAGC SW

Hi [redacted],

Yes, Friday afternoon, 12/16, at 1 PM or later, works for me. Let's see what works for the others.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, November 29, 2022 10:13 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi Steve,

That's a great question, and one that I'm not sure I have an answer to... I'm hopeful that as [redacted] has time to get settled into this role (and [redacted], too), it'll become more clear what capacity SW will have with the total FTE of 1.5. So perhaps it's a wait and see?

In the meantime, I would love to opportunity to come up with a plan for [redacted] workflow until her counterpart is hired.

Given your time away, should we aim for the afternoon of 12/16?

Let me know - thank you!
[redacted]

[redacted] LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, November 29, 2022 9:22 AM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

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Hi [redacted]

I think that you've made a clear and compelling argument for why having one social worker for the CAGC at 36 hours/week just doesn't cut it. It's my understanding that hiring a replacement for [redacted]) at 0.6 FTE (24 hours/week) is in process. Do you think that additional FTE will enable the ability for SW to carry out the tasks that have been so valued in our interdisciplinary model of care?

I'm happy to participate in a meeting to further discuss CAGC SW. I have most flexibility on Friday afternoons, but will be away 12/1-12/11.

Thanks very much,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Monday, November 28, 2022 11:18 PM
To: [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi everyone,

My apologies for the delay in my reply... and thank you for your thoughtful responses!

We hear you loud and clear - having SW do an initial assessment seems very important! We trust you know what your patients & families need.

However, the feedback we have been hearing from [redacted] for a long time is that their job responsibilities had become unsustainable. Doing all the pre-clinic assessments, helping families get connected with qualified community mental health professionals, and providing general and crisis support to established families had become too heavy of a workload (and this was with the help of 2 MSW students and some time from [redacted] (.2 FTE)).

We would like to re-define the essential tasks of SW in the CAGC, to ensure that we are expecting a reasonable amount of work out of [redacted] during her 36 hour work-week.

Can we find a time to meet in the next week and discuss the role of SW in CAGC going forward?

I assume you all are busier than I am, so please let me know when it's a good time to meet. Generally, I'm available most times except for Mondays and Thursday mornings.

A million thanks! And we are really looking forward to talking this through with you all.

[redacted]

[redacted] LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012

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San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Wednesday, November 23, 2022 12:32 PM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks, [redacted] for putting so much thought into this. I feel strongly that the social worker, not the scheduler, takes full responsibility for any pre-clinic contact with the family aside from the scheduling. The pre-clinic questionnaire and social work contact is actually the beginning of the gender care prior to the first visit and requires someone trained to take on this role. To date, the social work team has been invaluable in this regard.

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Wednesday, November 23, 2022 11:00 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC SW

Good morning everyone,

[redacted] and I had a productive meeting with [redacted] last week about how to use this transitional time to better streamline patients' entry into the CAGC clinic.

Our understanding of the current state is: [redacted] contacts all patients with new patient appointments in the upcoming month, and completes the following questionnaire over the phone. This information is then put into the chart for providers to have at the ready for the patient's first visit. Copy of the assessment is here:
CAGC First Visit Questionnaire (1).docx

Our proposal for changes to make: [redacted] will conduct a simplified version of the questionnaire with families over the phone when she calls to schedule them. A week before their appointment, she will do a reminder call & offer to have a Social Worker ([redacted]) contact them for any additional support needs. Additionally, if [redacted] identifies any potential complicating psychosocial factors during her phone conversations with families (ie unclear custody arrangement, patient with significant mental health concerns, transportation/insurance access issues, etc), [redacted] will send a referral to [redacted] via the Apex referral system for follow-up.

Curious to know a few things...

1. What are your initial thoughts/responses/concerns to this proposed change of workflow?
2. Is a SWer required to make contact with every patient, or is it permissible for it to be as-indicated?
3. Can this questionnaire be simplified at all?

Happy to sit and have a meeting about this if you'd prefer! Thanks again for your partnership.

[redacted] & [redacted]

[redacted], LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

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UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 4:23 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>[redacted]
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi [redacted],

The DPH grant is ending as of 11/30/22, so all CAGC Social Work support going forward will be from the Medical Center. I'm hoping you and [redacted] can soon resolve the total Social Work FTE.

Please keep me posted on the search for the new CAGC Social Worker position.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 4:00 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: RE: CAGC SW

Hello,

I was also under the impression that we had 2x 0.9 positions, but recently heard differently and was told we have 1.6 total for CACG. I will continue to explore this further.
If we actually do have only 1.6, do we still have access to the .3 FTE from the DPH grant?

Also, we have hired for the 2nd position, [redacted] is set to start on 11/7. We will send out a bio to the team soon.
I submitted an eRF to replace [redacted] and am waiting for this to be approved and posted.

Thank you,

[redacted] **LCSW**
Pediatric Social Work Manager
UCSF Benioff Children's Hospital, San Francisco

Pediatric Social Work Department
1975 4th Street, Box 4012 | San Francisco, CA 94158
Office: 415.514-7668
Email: [redacted]

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Pronouns: she, hers, her, ella

UCSF Benioff Children's Hospitals

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, October 28, 2022 3:21 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Hi All,

I have cc'd [redacted]. We (the CAGC) have had a 0.9 FTE Social Worker paid for by the Medical Center, and, as on 2/17/22 (see email from [redacted], below), we were awarded an additional 0.9 FTE Social Worker based on the needs of the CAGC. Therefore, we should have two Social Workers, each at 0.9 FTE for the CAGC ASAP --The funding for the 2nd Social Worker was approved 8 months ago!

I understand that we have a replacement for the position currently held by [redacted] who will be leaving UCSF as of 11/11/22.

Please let me know if the position for the 2nd Social Worker has been posted, and if not yet posted, please let me know when this is likely to happen. Again, the funding for the 2nd Social Worker was approved 8 months ago, so we really need to move forward with the hiring process.

Thank you,

Steve

From: [redacted]@ucsf.edu>
Sent: Thursday, February 17, 2022 4:42 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC FTE Requests

All,

I have great news!

We received final approval on the 4.9 FTE investment request for CAGC. The positions are currently being posted by HR. Here's what was approved:

- 1.0 FTE Psychologist
- 1.0 FTE Practice Coordinator
- 0.9 FTE Social Worker
- 1.0 FTE LVN
- 1.0 FTE RN

I want to thank all of you for your patience as we worked to get this to the finish line. I also want to give kudos to [redacted] for her leadership in getting the request organized and building a compelling business case!

Thanks,

[redacted]

[redacted] MBA
Director
Children's Ambulatory Services
UCSF Health

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Office: (415) 514-6388
Mobile: [redacted]

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 3:02 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu> [redacted]
<[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: CAGC SW

Hi,

Please contact Steve and [redacted] regarding that information.

Thank you,

Dr. [redacted], DNP, AC-PNP-BC
Nurse Practitioner
UCSF Pediatric Endocrinology

From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:18 AM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC SW

Thanks [redacted]

Any info on where the funding from the other .9 FTE is from, if it's not also Medical Center?

Thanks,
[redacted]

[redacted] LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: [redacted]@ucsf.edu>
Sent: Friday, October 28, 2022 10:17 AM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC SW

Here is the response on SW FTE:

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2 x 0.9 FTE and one of those 0.9 FTE is from med center

[redacted], PNP
UCSF Pediatric Endocrinology
Assistant Clinical Professor
Department of Family Health Care
UCSF School of Nursing

Obtained via CPRA by Judicial Watch, Inc.

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, December 16, 2022 5:00 PM PST
To: [redacted]@ucsf.edu>
Subject: Re: CAGC Clinic Coordinator

Hi [redacted]

I was about to reach out to [redacted] and realize I don't have her last name. Please let me know so I can make contact.

Thanks, and have a nice weekend,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, December 9, 2022 3:33 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: CAGC Clinic Coordinator

Thank you!!

[redacted] PNP
UCSF Pediatric Endocrinology
Assistant Clinical Professor
Department of Family Health Care
UCSF School of Nursing

> On Dec 9, 2022, at 16:29, Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu> wrote:
>
> Hi [redacted]
> Thanks for bringing this to my attention. I will contact [redacted] early next week.
> Steve
>
> Get Outlook for iOS
>
> ---
>
> **From:** [redacted]@ucsf.edu>
> **Sent:** Friday, December 9, 2022 11:50:13 AM
> **To:** [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
> **Subject:** CAGC Clinic Coordinator
>
> Dear Team,
>
> I have been meeting with [redacted] for training in her role as clinic coordinator. Her current priorities are (1) scheduling patients (new & follow up), (2) transitioning adult patients to adult providers, (3) distributing the new patient packet once finalized.
>
> My Concern: [redacted] has recently informed her that she will now be doing visit prior authorizations, which is the work [redacted] does. This will create a workload burden, preventing [redacted] for coordinating clinic activities. In addition, this is not the work that [redacted] was hoping to do for our patients.

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Do you want [redacted] to focus her time on authorization work for visits? If not, please contact [redacted] to discuss.

Dr. [redacted], DNP, AC-PNP-BC
Nurse Practitioner
UCSF Pediatric Endocrinology

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, December 16, 2022 5:42 PM PST
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: eRf # 83929

Not great news, but please keep us posted.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, December 16, 2022 5:04 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: eRf # 83929

Wow, this is big news. Thank you for letting us know.

[redacted] **LCSW**
Pediatric Social Work Manager
UCSF Benioff Children's Hospital, San Francisco

Pediatric Social Work Department
1975 4th Street, Box 4012 | San Francisco, CA 94158
Office: 415.514-7668
Email: [redacted]@ucsf.edu
Pronouns: she, hers, her, ella

UCSF Benioff Children's Hospitals

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From: [redacted]@ucsf.edu>
Sent: Friday, December 16, 2022 5:00 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: eRf # 83929

[redacted] & [redacted]

I'll let [redacted] speak to the budgeted FTE.

But I did want to share that UCSF has officially implemented a hiring freeze given the significant budget deficit we're facing - this includes all new positions, replacement positions, posted positions, and temp requests. It's not entirely clear when we will have approval to move forward but I will continue to keep the group apprised as we receive additional insight. My apologies as I know this is disappointing news.

Thanks,

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

[redacted]

From: [redacted]@ucsf.edu>
Sent: Friday, December 16, 2022 4:52 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: eRf # 83929

Hi [redacted] and [redacted]

Steven and I would like to follow up on the status of the eRF for our Child and Adolescent Gender Clinic position. This is a replacement position for our previous SW, [redacted]. Since submitting the eRF in October, we have learned the FTE is actually .6 not .9. Ideally, we would really like to move forward with recruitment as soon as possible, so any information would be very much appreciated.

Thank you,

[redacted] **LCSW**
Pediatric Social Work Manager
UCSF Benioff Children's Hospital, San Francisco

Pediatric Social Work Department
1975 4th Street, Box 4012 | San Francisco, CA 94158
Office: 415.514-7668
Email: [redacted]@ucsf.edu
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Obtained via CPRA by Judicial Watch, Inc.

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, December 16, 2022 6:34 PM PST
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>
Subject: Re: Wong_Peds Applicant Interviews

Hi [redacted] and [redacted],

Happy to participate—perhaps a group zoom?

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, December 16, 2022 1:00 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen
<Stephen.Rosenthal@ucsf.edu>
Subject: RE: Wong_Peds Applicant Interviews

Thanks [redacted]!

I am very happy to put together a time to meet with [redacted] based on everyone's availabilities or forward your e-mail addresses and have [redacted] reach out. So yes, [redacted], [redacted], and Stephen please let us know if that's okay and thank you in advance for considering!

Best,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Friday, December 16, 2022 12:02 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen
<Stephen.Rosenthal@ucsf.edu>
Subject: Wong_Peds Applicant Interviews

Hi [redacted] and [redacted],

Thank you for organizing the residency interviews! I met with [redacted] today, who has a strong interest in LGBTQ+ youth and learning about research on the effects of puberty blockers and cross-sex hormones on transgender children. She is interested in advocacy, medical education, and potentially research/fellowship in pediatric endocrinology (or adolescent medicine). I suggested that she meet with my wonderful gender center colleagues in peds endocrine ([redacted], [redacted], and Steve, copied here), if they are able and willing, since she had specific questions about how a resident might be able to get involved in research opportunities. [redacted], [redacted], and Steve, let me know if that's OK!

[redacted], I wasn't sure if you would be able to make connections or set up additional interviews, or if you would recommend that I put [redacted] in contact with them directly?

Thank you!
[redacted]

From: [redacted]@ucsf.edu
When: 10:30 AM - 11:45 AM December 16, 2022

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Subject: Wong_Peds Applicant Interviews
Location: Zoom

Thank you for volunteering to interview pediatric intern applicants on Friday, December 16, 2022

If you have any urgent issues on applicant day,
please contact [redacted] asap at [redacted]

We are using a text messaging system. If you provided us with a cell phone number, we will send you a text reminder prior to your interviews.

The interviewer survey can be found here:https://ucsf.co1.qualtrics.com/jfe/form/SV_8reUPSEqk2eLGqq
We are using one survey link this year; please click the above link twice so you can complete the survey for both of the applicant you are interviewing today.

You are scheduled to interview:

Interview #1 – 10:30 AM - 11:00 AM
Applicant Name: [redacted] **Applicant Medical School:** [redacted] **Applicant Cell Phone:** [redacted] **Track Applicant Applying to: PLUS** **Zoom Link for interview:Recruit 12** **pw:** [redacted]
Interview#2 – 11:15 AM - 11:45 AM
Applicant Name: [redacted] **Applicant Medical School:** [redacted] **Applicant Cell Phone:** [redacted] **Track Applicant Applying to: PLUS** **Zoom Link for interview:Recruit 22** **pw:** [redacted]

Sincerely,
[redacted] and the Peds Intern Selection Team

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@ucsf.edu>
Sent: Saturday, December 17, 2022 8:30 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: CAGC Clinic Coordinator

Hi Steve,

It is [redacted] I just found out that [redacted] will become [redacted] manager sometime soon, however. Perhaps reaching out to her would be better?

I hope you have a wonderful weekend!

[redacted], PNP
UCSF Pediatric Endocrinology
Assistant Clinical Professor
Department of Family Health Care
UCSF School of Nursing

> On Dec 16, 2022, at 18:00, Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu> wrote:
>
> Hi [redacted],
>
> I was about to reach out to [redacted] and realize I don't have her last name. Please let me know so I can make contact.
>
> Thanks, and have a nice weekend,
>
> Steve
>
> Stephen M. Rosenthal, M.D.
> Professor of Pediatrics
> Division of Pediatric Endocrinology
> Medical Director, Child and Adolescent Gender Center
> University of California, San Francisco
> Mission Hall: Global Health and Clinical Sciences
> 550 16th St., 4th Floor, #4635
> San Francisco CA 94143-0434
> Pronouns: he/him/his
>
> Director, World Professional Association for Transgender Health
> Past Vice President and Director, Endocrine Society
> Past President, Pediatric Endocrine Society
>
> Tel.: (415) 476-2266
> Fax: (415) 476-5356
> email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, December 9, 2022 3:33 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: CAGC Clinic Coordinator

Thank you!!

[redacted], PNP
UCSF Pediatric Endocrinology
Assistant Clinical Professor
Department of Family Health Care
UCSF School of Nursing

> On Dec 9, 2022, at 16:29, Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu> wrote:
>
> Hi [redacted],
> Thanks for bringing this to my attention. I will contact [redacted] early next week.

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Steve

Get Outlook for iOS

From: [redacted]@ucsf.edu>
Sent: Friday, December 9, 2022 11:50:13 AM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC Clinic Coordinator

Dear Team,

I have been meeting with [redacted] for training in her role as clinic coordinator. Her current priorities are (1) scheduling patients (new & follow up), (2) transitioning adult patients to adult providers, (3) distributing the new patient packet once finalized.

My Concern: [redacted] has recently informed her that she will now be doing visit prior authorizations, which is the work [redacted] does. This will create a workload burden, preventing [redacted] for coordinating clinic activities. In addition, this is not the work that [redacted] was hoping to do for our patients.

Do you want [redacted] to focus her time on authorization work for visits? If not, please contact [redacted] to discuss.

Dr. [redacted], DNP, AC-PNP-BC
Nurse Practitioner
UCSF Pediatric Endocrinology

Obtained via CPRA by Judicial Watch, Inc.

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From: [redacted]@ucsf.edu>
Sent: Monday, December 19, 2022 8:15 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: RE: Wong_Peds Applicant Interviews

Thanks Steve!

I'll contact [redacted] and get some available dates\times and pitch them to you all and we will try to match availabilities.

Best,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, December 16, 2022 6:35 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>
Subject: Re: Wong_Peds Applicant Interviews

Hi [redacted] and [redacted],

Happy to participate—perhaps a group zoom?

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
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Pronouns: he/him/his

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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, December 16, 2022 1:00 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen
<Stephen.Rosenthal@ucsf.edu>
Subject: RE: Wong_Peds Applicant Interviews

Thanks [redacted]

I am very happy to put together a time to meet with [redacted] based on everyone's availabilities or forward your e-mail addresses and have [redacted] reach out. So yes, [redacted], [redacted], and Stephen please let us know if that's okay and thank you in advance for considering!

Best,
REX

From: [redacted]@ucsf.edu>
Sent: Friday, December 16, 2022 12:02 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen
<Stephen.Rosenthal@ucsf.edu>
Subject: Wong_Peds Applicant Interviews

Hi [redacted] and [redacted],

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Thank you for organizing the residency interviews! I met with [redacted] today, who has a strong interest in LGBTQ+ youth and learning about research on the effects of puberty blockers and cross-sex hormones on transgender children. She is interested in advocacy, medical education, and potentially research/fellowship in pediatric endocrinology (or adolescent medicine). I suggested that she meet with my wonderful gender center colleagues in peds endocrine ([redacted], [redacted] and Steve, copied here), if they are able and willing, since she had specific questions about how a resident might be able to get involved in research opportunities. [redacted], [redacted] and Steve, let me know if that's OK!

Rex, I wasn't sure if you would be able to make connections or set up additional interviews, or if you would recommend that I put [redacted] in contact with them directly?

Thank you!
[redacted]

From: [redacted]@ucsf.edu
When: 10:30 AM - 11:45 AM December 16, 2022
Subject: Wong_Peds Applicant Interviews
Location: Zoom

Thank you for volunteering to interview pediatric intern applicants on Friday, December 16, 2022

If you have any urgent issues on applicant day,
please contact [redacted] asap at [redacted]

We are using a text messaging system. If you provided us with a cell phone number, we will send you a text reminder prior to your interviews.

The interviewer survey can be found here: https://ucsf.co1.qualtrics.com/jfe/form/SV_8reUPSEqk2eLGqq
We are using one survey link this year; please click the above link twice so you can complete the survey for both of the applicant you are interviewing today.

You are scheduled to interview:

Interview #1 – 10:30 AM - 11:00 AM
Applicant Name: [redacted] **Applicant Medical School:** [redacted] **Applicant Cell Phone:** [redacted] **Track Applicant Applying to: PLUS** **Zoom Link for interview: Recruit 12** **pw:** [redacted]
Interview#2 – 11:15 AM - 11:45 AM
Applicant Name: [redacted] **Applicant Medical School:** [redacted] **Applicant Cell Phone:** [redacted] **Track Applicant Applying to: PLUS** **Zoom Link for interview: Recruit 22** **pw:** [redacted]

Sincerely,
[redacted] and the Peds Intern Selection Team

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, December 19, 2022 10:15 AM PST
To: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>
Subject: Re: Dr. [redacted]'s effort

Hi [redacted],

I'm confused by this email. Dr. [redacted] and I are partially funded by 2 NIH grants where the administrative core is at CHLA. Which of the 2 grants are you referring to? If it's the one on which I am the PI, Dr. [redacted] is funded at 5% effort, and there have been no gaps in funding for the last 2 years. If you're referring to the NIH grant on which Dr. [redacted] is PI (and I'm co-I), I was under the impression that there also have been no gaps in funding, so I don't understand why Dr. [redacted]'s research effort from January-June, 2022 wouldn't be covered by these grants.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Monday, December 19, 2022 9:18 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>
Subject: Dr. [redacted]s effort

Hi Dr. Rosenthal and Dr. [redacted],

Dr. [redacted]'s effort was being charged to the department. This was due to the UCLA award being delayed. We recently received the award, but it has a start date of June/July which means we can't charge the effort for Jan-May 2022. Since we don't have another award to charge it and the department/division will not pay, I was wondering if we would be able to charge more effort on one of Dr. Rosenthal's projects? If we charge more effort on Dr. Rosenthal's projects, for the future we can adjust it where we would charge Dr. Rosenthal less and charge more on the UCLA one. The total charge would be $6,550.

Please let me know if we need to meet about this or need further clarification.

Thank you,
[redacted]

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, December 19, 2022 10:34 AM PST
To: [redacted]@ucsf.edu>
Subject: Re: CAGC Clinic Coordinator

Thanks, [redacted]. I'll f/u with [redacted]

I hope you had a nice weekend!

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
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Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
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To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: CAGC Clinic Coordinator

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I hope you have a wonderful weekend!

[redacted] PNP
UCSF Pediatric Endocrinology
Assistant Clinical Professor
Department of Family Health Care
UCSF School of Nursing

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Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, December 9, 2022 3:33 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: CAGC Clinic Coordinator

Thank you!!

[redacted] PNP
UCSF Pediatric Endocrinology
Assistant Clinical Professor
Department of Family Health Care
UCSF School of Nursing

On Dec 9, 2022, at 16:29, Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu> wrote:

Hi [redacted]
Thanks for bringing this to my attention. I will contact [redacted] early next week.
Steve

Get Outlook for iOS

From: [redacted]@ucsf.edu>
Sent: Friday, December 9, 2022 11:50:13 AM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC Clinic Coordinator

Dear Team,

I have been meeting with [redacted] for training in her role as clinic coordinator. Her current priorities are (1) scheduling patients (new & follow up), (2) transitioning adult patients to adult providers, (3) distributing the new patient packet once finalized.

My Concern: [redacted] has recently informed her that she will now be doing visit prior authorizations, which is the work [redacted] does. This will create a workload burden, preventing [redacted] for coordinating clinic activities. In addition, this is not the work that [redacted] was hoping to do for our patients.

Do you want [redacted] to focus her time on authorization work for visits? If not, please contact [redacted] to discuss.

Dr. [redacted] DNP, AC-PNP-BC
Nurse Practitioner
UCSF Pediatric Endocrinology

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, December 19, 2022 10:39 AM PST
To: [redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>
Subject: Fw: CAGC Clinic Coordinator

Hi [redacted],

I hope you are doing well!

I am forwarding the email, below, from [redacted](cc'd here), as she told me that she understands that you will soon become supervisor for [redacted] I share the concerns expressed by [redacted] and feel that [redacted] should not have to take on authorization work for CAGC clinic visits.

Thanks very much,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
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Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, December 9, 2022 9:50 AM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC Clinic Coordinator

Dear Team,

I have been meeting with [redacted] for training in her role as clinic coordinator. Her current priorities are (1) scheduling patients (new & follow up), (2) transitioning adult patients to adult providers, (3) distributing the new patient packet once finalized.

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Dr. [redacted], DNP, AC-PNP-BC
Nurse Practitioner
UCSF Pediatric Endocrinology

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, December 19, 2022 10:55 AM PST
To: [redacted]@thisgender.org>
Subject: Re: Free Desk Copy of Zebras Among Us

Hi [redacted],

Congratulations to you and [redacted] on your book!

Please feel free to send the copy to my home address:

[redacted]

Thanks and Happy Hanukkah!

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
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Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@thisgender.org>
Sent: Wednesday, December 14, 2022 12:53 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Free Desk Copy of [redacted]

This Message Is From an Untrusted Sender
You have not previously corresponded with this sender.

Greetings Dr. Rosenthal,
[redacted] and I are interested in sending you a copy of our recent publication in gratitude for your service to improving trans*+ health and increasing social justice.
[redacted]

Should we use the mailing address below?

Dr. Steven Rosenthal
UCSF Medical School
550 16th Street
San Francisco, CA 94158

More information on the book is here: https://www.cambridgescholars.com/product/978-1-5275-7227-0

Looking forward to confirming your mailing address, and Happy Channukah!
-[redacted]

[redacted] (he/they)
[redacted]
thisgender.org
montananorthern.academia.edu/[redacted]

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@ucsf.edu>
Sent: Monday, December 19, 2022 12:10 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: CAGC Clinic Coordinator

Hi Stephen, [redacted]

Will discuss with [redacted] and [redacted] and report back.

Thank you,
[redacted]

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted] Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
Pediatric Developmental Medicine
UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
Clinic: 415-353-2080 Fax: 415-502-0014

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, December 19, 2022 10:39 AM
To: [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Fw: CAGC Clinic Coordinator

Hi [redacted]

I hope you are doing well!

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Thanks very much,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
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Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, December 9, 2022 9:50 AM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: CAGC Clinic Coordinator

Dear Team,

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Do you want [redacted] to focus her time on authorization work for visits? If not, please contact [redacted] to discuss.

Dr. [redacted], DNP, AC-PNP-BC
Nurse Practitioner
UCSF Pediatric Endocrinology

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, December 19, 2022 12:16 PM PST
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: CAGC Clinic Coordinator

Thanks, [redacted]

Steve

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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Monday, December 19, 2022 12:10 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: CAGC Clinic Coordinator

Hi Stephen, [redacted]

Will discuss with [redacted] and [redacted] and report back.

Thank you,
[redacted]

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted] Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
Pediatric Developmental Medicine
UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
Clinic: 415-353-2080 Fax: 415-502-0014

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, December 19, 2022 10:39 AM
To: [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Fw: CAGC Clinic Coordinator

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[redacted]

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Sent: Friday, December 16, 2022 6:35 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>
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Cc: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen
<Stephen.Rosenthal@ucsf.edu>
Subject: RE: Wong_Peds Applicant Interviews

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Best,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Friday, December 16, 2022 12:02 PM
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Cc: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen
<Stephen.Rosenthal@ucsf.edu>
Subject: Wong_Peds Applicant Interviews

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Thank you!
[redacted]

From: [redacted]@ucsf.edu
When: 10:30 AM - 11:45 AM December 16, 2022
Subject: Wong_Peds Applicant Interviews
Location: Zoom

Thank you for volunteering to interview pediatric intern applicants on Friday, December 16, 2022

If you have any urgent issues on applicant day,
please contact [redacted] asap at [redacted]

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The interviewer survey can be found here: https://ucsf.co1.qualtrics.com/jfe/form/SV_8reUPSEqk2eLGqq
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Applicant Name: [redacted] **Applicant Medical** [redacted] **Applicant Cell Phone:** [redacted] **Track Applicant Applying to: PLUS** **Zoom Link for interview: Recruit 12** **pw:** [redacted]
Interview#2 – 11:15 AM - 11:45 AM
Applicant Name: [redacted] **Applicant Medical School:** [redacted] **Applicant Cell Phone:** [redacted] **Track Applicant Applying to: PLUS** **Zoom Link for interview: Recruit 22** **pw:** [redacted]

Sincerely,
[redacted] and the Peds Intern Selection Team

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, December 20, 2022 8:39 AM PST
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From: [redacted]@ucsf.edu>
Sent: Tuesday, December 20, 2022 8:17:42 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: Wong_Peds Applicant Interviews

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To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
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Tel.: (415) 476-2266
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Sent: Friday, December 16, 2022 1:00 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted], [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen
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Sincerely,
[redacted] and the Peds Intern Selection Team

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From: [redacted]@ucsf.edu>
Sent: Tuesday, December 20, 2022 9:29 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: Wong_Peds Applicant Interviews

Thanks Steve! I will reach out to everyone again and get some dates in January.

You too have a great holiday season!

Best,
[redacted]

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Track Applicant Applying to: PLUS
Zoom Link for interview: Recruit 22
pw: [redacted]

Sincerely,
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Primary Care in Transgender Persons

Brittany L. Whitlock, BS[a], Elizabeth S. Duda, BA[a], Molly J. Elson, BA[a], Paul Parker Schwab, BBA[a], Ogul Ersin Uner, BA[a], Shawn Wen, MS[a], Jason S. Schneider, MD[b,*,1]

KEYWORDS

• Transgender • Primary care • Prevention • Screening

KEY POINTS

- The preventive health care needs of transgender persons are nearly identical to the rest of the population.
- Special consideration should be given to the impact of gender-affirming hormone regimens and surgical care on preventive screenings.
- To avoid creating additional barriers to access, special attention must be given to creating a welcoming and inclusive health care system for transgender persons.
- Providers must consider the unique impact that a gender identity and expression different from the assigned gender at birth affects patient-provider interactions, including the history, physical examination, and diagnostic testing.

INTRODUCTION

A majority of health issues affecting transgender and gender nonbinary people are no different from those of the remainder of the population. Highlighted in this article and in other articles in this special issue are topics in primary care that are unique to transgender populations. The authors use a broader view of the health care system, beyond the hospital or outpatient setting, to delineate aspects of transgender health care deserving of special consideration.

SETTING THE SCENE—CONSIDERATIONS FOR THE OFFICE

Multiple social determinants of health have a negative and disproportionate impact on transgender people: violence, economic hardship, unemployment, and housing

Conflicts of Interest: None.
Funding sources: B.L. Whitlock, E.S. Duda, M.J. Elson, P.P. Schwab, O.E. Uner, and S. Wen: None; J.S. Schneider: National Institutes of Health and Emory Medical Care Foundation.
[a] Emory University School of Medicine, 100 Woodruff Circle, Suite 231, Atlanta, GA 30322, USA; [b] Division of General Medicine and Geriatrics, Department of Medicine, Emory University School of Medicine, 49 Jesse Hill Jr Drive Southeast, Atlanta, GA 30303, USA
[1] Senior author.
* Corresponding author.
E-mail address: jsschne@emory.edu

Endocrinol Metab Clin N Am 48 (2019) 377–390
https://doi.org/10.1016/j.ecl.2019.02.004 **endo.theclinics.com**
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insecurity, among others.[1] Transgender people also experience prohibitive inequities when finally accessing quality health care. Many transgender people have been refused health care services due to their gender identity, and many more report delaying or avoiding health care due to past experiences of harassment in medical settings and lack of provider knowledge.[2,3] For these reasons, it is imperative that health care providers and their staff be well educated in best practices regarding the care for transgender individuals.

Staff Training

Transgender people often are subject to prejudice within all levels of the health care system, and thus the first step in delivery of transcompetent care is to establish a practice as a safe space from the first point of contact with transgender patients. Education of all health care and frontline staff on standards of respect toward transgender people is highly recommended, and discourse in the practice should reflect this training continuously.

The following topics have been suggested by the Gay & Lesbian Medical Association (GLMA) to include in a staff training program[4]:

1. Use of appropriate language when addressing or referring to patients and/or their significant others
2. Learning how to identify and challenge any internalized discriminatory beliefs about lesbian, gay, bisexual, transgender, queer, and other sexual or gender non-conforming people (LGBTQ+)
3. Basic familiarity with important LGBTQ+ health issues (eg, impacts of homophobia, discrimination, harassment, and violence; mental health and depression; substance abuse; safe sex; partner violence; HIV/sexually transmitted infections)
4. Indications and mechanisms for referral to LGBTQ+identified or LGBTQ+friendly providers

Additional resources concerning education on transgender awareness can be found in the GLMA 2005 *Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients*.[4]

Elements of Competent Care

There are several principles that should be followed by all staff and health care personnel to provide culturally sensitive care to transgender patients.

- Name and pronouns—always address patients by their stated name and personal pronouns.
- Privacy—prioritize patient privacy. Do not assume that partners, employers, or family members are informed of a patient's gender identity.
- Terminology—providers should be aware of and comfortable using basic terminology used by the transgender community. **Table 1** lists some basic terminology as it is most often used, but providers should be aware that the language used to discuss transgender identity is constantly evolving and should attempt to use the terminology that individual patients prefer.

Electronic Health Record

An often overlooked but essential aspect of providing quality care for transgender patients is making proper adaptations to the electronic health record (EHR) of a health system. Many transgender patients identify with a name or gender identity (GI) that is different from that assigned at birth. Making EHRs compliant with a patient's

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Table 1
Definition of common terminology used in the transgender community

Term	Definition
Sex	Sex is assigned at birth to individuals based on external genitalia, internal genitalia, and chromosomes.
Gender identity	A person's intrinsic sense of self as the person relates to gender
Gender expression	Outward characteristics like clothing, behaviors, and appearance that express a person's sense of gender. This is separate from gender identity; a person may identify as one gender and express components of another.
Transgender person	An individual whose gender identity is different from the gender assigned at birth
Cisgender person	An individual whose gender identity is the same as that assigned at birth
Transmasculine person	A person who has a masculine-spectrum gender identity and was assigned female gender at birth
Transfeminine person	A person who has feminine-spectrum gender identity and was assigned male at birth
Gender dysphoria	Psychological distress caused by discrepancy between a person's gender identity and gender assigned at birth, often specifically regarding secondary sex characteristics
Nonbinary person[a]	An individual who identifies as neither male nor female but rather between the 2 extremes of the gender spectrum
Agender person[a]	An individual who identifies as having no gender or as being outside of the male-female spectrum.

[a] Some, but not all, nonbinary and agender people identify as transgender.

Adapted from Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California San Francisco. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People; 2nd edition. Deutsch MB, ed. June 2016. Available at: www.transhealth.ucsf.edu/guidelines; with permission.

appropriate identifiers ensures improved communication and accurate health documentation for transgender patients and can prevent recurrent errors in identification that may deter patients from seeking care.[5]

The World Professional Association for Transgender Health released guidelines on EHR use in transgender patient care.[6] These recommendations are summarized:

1. Name, GI, and pronouns identified by patients should be regarded as demographic information, like ethnicity. The system should immediately and obviously notify the provider of a patient's relevant identifiers on opening of a patient's chart if they do not match the legally documented information. The legally documented name and gender identity can still appear on the EHR and continue to be used for billing and identity verification if the patient has not completed the legal process of name, gender, and/or gender transition.
2. The EHR should have a structured inventory of a patient's medical transition history and current anatomy. If possible, a master list of anatomic organs for each patient can allow for individualized history and physical examination templates. Future system updates may allow for anatomy-based reminders of any relevant screening procedures recommended by the US Preventive Services Task Force (USPSTF).
3. The system should be able to accommodate legal and medical transition in the EHR. This involves changing the gender and anatomic inventory included in the medical record with ease and continuously educating the staff (eg, reference laboratory) to use the correct names and pronouns. Key personnel in the health

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system should be familiar with state-based requirements for legal name, gender, and/or gender marker changes.

SPECIAL CONSIDERATIONS IN THE HISTORY AND PHYSICAL

This section outlines specialized components that should be included in a new patient visit or complete history and physical with a transgender patient.

History

General principles of the history

The history should attempt to catalog medical and surgical interventions and health behaviors that may affect provided care. Most medical care sought by transgender patients, however, is unrelated to their gender identity, and it is unnecessary to discuss gender-related health at every visit. It also should be kept in mind that not all transgender patients desire alteration of their bodies through hormones or surgery. Providers should inquire about physical changes but not assume that they are desired or have occurred.

Special considerations of a sensitive history

- Past medical and surgical history
  - Organ inventory: perform an organ inventory to assess what organs and/or modifications the patient has. Do not assume a patient's anatomy based on the gender presentation.
  - Procedures: inquire regarding what, if any, gender-affirming procedures the patient has had. These may include
    - Transfeminine patients: breast augmentation, orchiectomy, vaginoplasty, labiaplasty, cosmetic procedures, electrolysis, and injectable silicone use
      - If the patient endorses use of injectable silicones, further investigate where the procedure was performed. Many transfeminine individuals participate in pumping parties, where industrial-grade silicone is injected without professional supervision.[7] Improper use of injectable silicones can lead to complications, including infection, migrating globules, pneumonitis, granulomas, and pulmonary embolism.[7]
    - Transmasculine patients: mastectomy, hysterectomy, oophorectomy, vaginectomy, and genital reconstruction
  - Health conditions: ask about past or current conditions that may affect hormone therapy. These include cardiovascular disease, diabetes mellitus, psychiatric illness, liver disease, renal disease, HIV, venous thromboembolism, and hormonally mediated cancers.
  - Complications: if a patient is receiving hormone therapy, ask about potential complications regarding treatment.
- Medications
  - Regimen: ask about hormones a patient is taking, if any. Include past hormonal regimens.
  - Dose and delivery: ask about dose and delivery methods of hormonal regimens. Screen for practices of needle sharing.
  - Acquisition: ask how a patient is acquiring hormones. Many patients are prescribed hormones, whereas others may acquire supplies via the Internet or other means.
  - Efficacy: assess efficacy of patient's current regimen. Assess whether a patient's expectations about hormonal efficacy are realistic.

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- Family history
  - Conduct a thorough family history, specifically assessing for conditions affecting hormone therapy. This specifically includes venous thromboembolism, cardiovascular disease, and liver disease.[8]
  - Assess for reproductive cancer risk, including breast and endometrial cancers.
- Social history
  - Conduct a sensitive sexual history, recalling that sexual orientation is distinct from gender identity.
    - The sexual history should be a behavior-focused history that uses inclusive language about partners. Do not make assumptions about a partner's gender identity or the sexual behaviors engaged in.
    - Emphasize counseling about safe sex practices and sexually transmitted infection (STI) risk reduction. HIV and other sexually transmitted infections disproportionately affect the transgender community.[9]
  - Screen for intimate partner violence, which exists at a higher rate in the lives of transgender patients and is strongly connected to negative life outcomes.[2]
  - Substance abuse
    - Tobacco: rates of cigarette and e-cigarette use are higher in transgender populations compared with their cisgender counterparts.[10]
    - Alcohol: current data on alcohol abuse rates in transgender populations are minimal and do not provide an accurate assessment of community needs.[11]
- Mental health
  - Transgender patients have a statistically higher chance of experiencing anxiety and depression than the general population.[12] Therefore, regular assessment and counseling for psychiatric illness and suicidality are critical.

Physical

Guiding principles of the physical examination

There are several principles that should be followed throughout the physical examination to provide quality, culturally sensitive care to transgender patients.

- Anticipatory communication—before a patient is asked to undress, have an open discussion about what the physical examination will include. Explain why sensitive parts of the physical examination are important for the patient's health.
- Anatomy—physical examination should be based on the anatomy that is present, regardless of gender presentation. To this end, a sensitive history that inventories the organs and modifications present is essential.
- Language—be aware that common anatomic terminology may be distressing for transgender patients. To increase patient comfort, aim to reflect the language that the patient uses.
- Discretion and safety—only perform breast, genital, and rectal examinations when necessary. Additionally, a chaperone should be offered to the patient during sensitive examinations.[13]

Specialized components of a sensitive physical examination

- Awareness of secondary sex characteristic spectrum
  - Transfeminine patients using hormone therapy may have breast development, reduced muscle mass, reduced body hair, feminine fat distribution, softened skin, and testicles that are soft and reduced in size.[3,14]

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- Transmasculine patients using hormone therapy may have increased facial and body hair, acne, skin oiliness, enlarged clitoris, male pattern hair loss, deepened voice, increased upper body mass, and vaginal atrophy.[3,14]

- Transfeminine patients
  - Tucking: some transfeminine patients who have not undergone genital surgery may engage in tucking.[15] Tucking of the penis and testicles can lead to complications at the external inguinal ring, such as hernias and skin breakdown.[15]
  - Neovagina: a neovagina created by surgery differs from a natal vagina. It is a blind cuff with no cervix and its orientation may be more posterior. Use of an anoscope to assess vaginal walls may be preferred over a speculum.[3]
- Transmasculine patients
  - Binding: many transmasculine patients who have not undergone mastectomy engage in chest binding. Complications may include skin breakdown and musculoskeletal complaints.[15] Additionally, patients may be uncomfortable removing the binding for physical examination. Counseling about safe binding practices is recommended.[15]
  - Pelvic examination: some transmasculine patients may feel uncomfortable with the idea of penetration as it relates to their concept of gender, causing the pelvic examination to be especially traumatic and anxiety inducing. If a pelvic examination is indicated, special care should be taken to help patients manage this.
    - Reflect the anatomic language that the patient uses. Some transmasculine patients refer to the vaginal canal as their "front hole," whereas others prefer standard medical terminology.[3] Using a patient's preferred terminology can help reduce anxiety before and during the examination.
    - Discussion about the pelvic examination should happen while patients are fully dressed. Inquire about any past experiences with pelvic examinations, their comfort level with the examination, and what concerns they may have.[3] If patients are unduly distressed, it may be appropriate to delay the examination to a time when more rapport has been built.
    - Invite patients to use calming techniques. Some patients may prefer to bring a friend in the room, listen to music, or engage in a distracting conversation. A plan for relaxation techniques is best when discussed prior to examination.[16]
    - If anxiety cannot be managed in other ways, use of anxiolytic medications may be indicated.[16]
    - Some patients who take masculinizing hormones can experience increased discomfort during the pelvic examination due to atrophic vaginitis. This can be mitigated by administration of vaginal estrogen 1 week to 2 weeks prior to the examination.[3]

SCREENING

As outlined previously, a thorough history for transgender patients should include an organ inventory. Likewise, cancer screening should be based on the anatomy present rather than a patient's gender identity. This section outlines recommendations for cancer screening of reproductive organs, accounting for the presence or absence of gender-affirming hormones and procedures. For more on cancer in transgender patients, see Mary O. Stevenson and Vin Tangpricha's article, "Osteoporosis and Bone Health in Transgender Persons," in this issue.

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Breast Cancer

Transmasculine patients

The risk of breast cancer in transmasculine patients is most powerfully stratified by top surgery, because double mastectomy substantially reduces risk.[17] The risk is not zero, however, because any residual breast tissue, including the nipple areolar complex, is at risk for the development for carcinoma.[17,18] Based on current research, there does not seem to be an increased risk of breast cancers associated with the use of gender-affirming hormone therapy.[17]

The current recommendations suggest that transmasculine patients who have not had chest surgery follow the same breast cancer screening as cisgender women.[17] For patients who have undergone bilateral mastectomy, no breast cancer screening guidelines exist.[3]

Transfeminine patients

In the cisgender female population, an association exists between hormone replacement therapy (HRT) and increased risk of breast cancer.[19] Although data are limited, this same association has not been demonstrated in the population of transfeminine patients taking gender-affirming hormone therapy.[20,21] It is known, however, that although breast cancer incidence is not increased in transfeminine patients, it does occur at younger ages (mean age of 50) than in cisgender men (mean age of 70).[20] In transfeminine patients, breast cancer also tends to present with a palpable mass.[20]

Given the earlier age of incidence of breast cancer in transfeminine patients, it is recommended that patients over the age of 50 who have used feminizing hormones for at least 5 years to 10 years have screening mammography performed every 2 years.[3] Health care providers should educate their transgender patients on the signs and symptoms of breast cancer. Mammography may be performed both on breast tissue secondary to hormonal therapy and on surgically augmented breasts.[20]

Cervical Cancer

A majority of transmasculine patients have a cervix; patients with a cervix need cervical cancer screening.[22,23] Due to dysphoria associated with the procedure, however, transmasculine patients are less likely to be up to date on cervical cancer screenings than cisgender women.[16] Screening should follow the guidelines outlined by the USPSTF, which are not modified by gender identity or hormonal therapy.[23] Cervical cancer screening is not a requirement for testosterone therapy, however, and patient refusal of screening should not be used as a barrier for hormone therapy.[3]

Ovarian Cancer

In general, routine ovarian cancer screening is not recommended for patients lacking genetic or family risk factors, and this recommendation extends to transgender patients.[24] Although exogenous testosterone therapy does change the architecture of the ovaries,[25] there is no evidence that these changes increase the risk of ovarian cancer.[3]

Some, but not all, transmasculine patients undergo single or bilateral oophorectomy for the management of gender dysphoria. Those transmasculine individuals who require pelvic imaging of ovaries but have undergone vaginectomy may receive transrectal or transabdominal ultrasound.[3]

Endometrial Cancer

Routine screening for endometrial cancer is not recommended. Exogenous testosterone therapy increases risk of endometrial atrophy, not proliferation and

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carcinoma.[26] For this reason, amenorrhea in these patients is not believed to increase risk of endometrial hyperplasia.[26] In the event of unexplained vaginal bleeding in the setting of testosterone-induced amenorrhea, however, the cause of bleeding should be investigated.[3]

Testicular Cancer

The USPSTF recommends against screening for testicular cancer in the general population.[27] Anatomic dysphoria, however, may pose an obstacle to early self-diagnosis of testicular cancer. Appreciation of the magnitude of anatomic dysphoria is important when interpreting patient report of symptoms.[28]

Prostate Cancer

The risks and benefits of prostate cancer screening should be discussed with all persons possessing a prostate, regardless of hormone therapy or surgical history. The prostate is not removed during feminizing surgery. The relationship between risk of prostate cancer and total testosterone has been controversial.[29] It has been historically believed that high levels of testosterone increase risk for prostate cancer and, conversely, low levels are protective. More recent studies have failed to find consistent evidence for this, however, and estrogen therapy may be less protective than once believed.[30–33] Several studies have suggested that prostate specific antigen is suppressed in the setting of low androgens and perhaps a different threshold is needed for those on antiandrogen therapies.[31,34] Because the relationship between testosterone level and prostate cancer remains unclear, prostate cancer screening should be considered for all transfeminine patients.[35]

PREVENTION

HIV

HIV prevention and education are critically important in the transgender population. Data from the Centers for Disease Control and Prevention (CDC) illustrate that HIV prevalence among transfeminine patients is the highest among all risk groups, particularly among transfeminine patients of color.[2] The rate of undiagnosed HIV in the transgender population is high—recent studies reveal that the rate of transgender patients who are undiagnosed and unaware of their HIV infection is 57% compared with a 27% national average.[9]

The foundational elements of HIV prevention include condom use and pre-exposure prophylaxis. Condom use in insertive sex can be difficult in transfeminine patients taking feminizing hormones due to reduced penile engorgement during erection.[3] Condom use in transmasculine patients with phalloplasty has not been studied. For these reasons, pre-exposure prophylaxis is be an excellent prevention choice for many transgender patients engaging in high-risk sexual behavior. There are no significant drug-drug interactions with gender affirming hormones.[36] See Lin Fraser and Gail Knudson's article, "Education Needs of Providers of Transgender Population," in this issue, for further discussion on HIV in transgender populations.

Vaccinations

The CDC recommendations for vaccinations in transgender patients do not differ from that for cisgender patients. The CDC does specifically emphasize that all young adults through the age of 26 should receive the HPV vaccine.[37] Additionally, the hepatitis B vaccine[38] is recommended particularly for those who engage in high-risk sexual behavior. Please refer to CDC guidance for the most up-to-date vaccine recommendations.

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Cardiovascular Risk Reduction

Although it is well-established that supplementation of intrinsic sex hormones is linked to increases in cardiovascular disease risk, the cardiovascular risk of HRT in transgender people is poorly understood. Evidence suggests that HRT in transmasculine persons may elevate serum triglyceride and low-density lipoprotein levels while lowering high-density lipoprotein levels, although no increased risk has been demonstrated in adverse cardiovascular events.[39] In transfeminine patients, HRT has been well-documented to increase the risk of adverse cardiovascular events, specifically venous thromboembolism, myocardial infarction, and ischemic stroke. Furthermore, this risk may increase with long-term use.[39]

Some evidence suggests that transdermal estrogen may reduce the risk of venous thromboembolism in thrombophilic transfeminine patients.[40] Providers may improve the cardiovascular health of their transgender patients on HRT by encouraging smoking cessation and managing diabetes and lipid profiles.

Screening for traditional cardiovascular disease risk factors also is important.[41] Gender-affirming hormone regimens can have an impact on metabolism and affect risk of conditions like dyslipidemia and diabetes mellitus. Providers should use USPSTF recommendations and consider earlier or more frequent monitoring when eliciting a family history of premature cardiovascular disease.

Osteoporosis

Similarly, hormone regimens prescribed for transgender persons can affect bone metabolism. The traditional risk factors for osteoporosis also apply to transgender populations. Particular attention should be given to individuals postgonadectomy when hormonal regimens are discontinued.[41] A controversial area is whether or not to use assigned gender at birth when using traditional risk calculators like the Fracture Risk Assessment Tool score. A detailed discussion of bone health in transgender populations can be found elsewhere in this issue.

Contraception and Pregnancy

Transmasculine men who have not undergone hysterectomy can experience pregnancy and may have contraceptive needs. Nonhormonal options, such as condoms, are appropriate for everyone engaging in penetrative sex and have the added benefit of protection against STIs. Long-acting contraception methods that contain progesterone, such as the implant or intrauterine device, can serve a dual purpose of contraception and reduction of menstruation, especially in transmasculine patients who have recently started or are not using testosterone therapy.[42] Copper intrauterine devices are also a popular hormone-free contraceptive option, but patients should be aware that if they continue to menstruate, they can experience heavier cycles, which can exacerbate dysphoria.[43] For more on fertility considerations for transgender persons, see Michael F. Neblett II and Heather S. Hipp's article, "Fertility Considerations in Transgender Persons," in this issue.

COORDINATION OF CARE

Although transgender patients do have some unique health care needs that require specialist care, most of their health care needs overlap those of the general population and can be addressed by a primary care provider (PCP). PCPs are uniquely positioned to lead the coordination of specialist care to ensure transgender patients' health needs are being addressed comprehensively and longitudinally in an identity-affirming way. When referring to other providers, PCPs should ensure that specialists to whom they

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refer are gender affirming as well. Careful selection of referrals can help to prevent negative, stigmatizing experiences for transgender patients that could lead to disengagement from the health care system.[2,44]

Several nonprofit and community organizations exist that compile a list of clinics that specialize in transgender health care, including but not limited to University of California, San Francisco Center of Excellence for Transgender Health and the Trans Media Network.[3,45]

LEGAL ISSUES

Legal Identity Document Changes

Barriers to the alignment of legal documentation with gender identity stand in opposition to the physical and mental health of transgender individuals by restricting freedom of gender expression and increasing potential for harassment.[46] Health care providers are often given the role of gatekeeper for patients seeking changes to their legal identity documents, and thus it is imperative physicians stay abreast of current regulatory matters to provide the best care and guidance for their transgender patients.

Although there are efforts to make laws consistent across the nation, matters of amending legal identity documents depend on an intricate mix of both federal and state laws.

Federal documents

To change legal gender, a health professional must certify, in writing, that the patient has undergone "necessary" medical or psychological treatment for transition.[44,45] Currently, no particular clinical treatment, including hormones and surgery, has been determined necessary for all transgender patients, possibly opening the door to interpretation by individual providers.[3] The following United States federal bodies have adopted similar rules regarding changes to identity documents:

- Department of State, for issuing passports and consular birth certificates
- Social Security Administration
- Department of Homeland Security
- Veterans Health Administration
- Office of Personnel Management[47]

State documents

Many states fall in line with federal law; however, some require surgical intervention to change legal gender. As with the case of federal law, no specific surgery has been established as necessary for all transgender patients, leaving flexibility in interpretation by the provider.[3]

- Birth certificate: changing legal gender on a birth certificate is complex because this document is considered a vital record and accepted as official by many agencies. Birth certificates are administered through local and territorial jurisdictions and many require a court order and/or documentation from a surgeon confirming gender-affirming surgery to amend them. Several jurisdictions, however, have eliminated surgical requirements completely. Few states currently forbid or prohibit correction of gender designation on birth certificates.[48]
- Driver's license: driver's license changes depend on the state of residence. Departments of motor vehicles in approximately half of the states have removed surgical requirements for gender marker corrections.[48]
- Name change: in most jurisdictions, the legal name change procedure for transgender individuals is identical to that for nontransgender people because this is a nongendered process.[47]

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Once legal documents have been amended, it is important that legal name and gender are updated with insurance companies and medical providers to prevent denial of claims based on a mismatch of legal gender and gender-specific medical care. Providers may be required to contact the insurance company and advocate for their patient in circumstances of gender-specific denial.[3]

Legal Considerations for Minors

- Document changes: individuals under the age of 18 must have parental consent to change their legal name or gender marker on government identification. This process varies by state.
- Gender-affirming therapy: initiation of prescription hormone therapy has no set age limit and is up to the health provider's discretion. Both gonadotropin-releasing hormone analog and gender-affirming hormone administration require parental or guardian consent if a patient is under the age of 18.[3] For more on hormone therapy in minors, see Jessica Abramowitz's article, "Hormone Therapy in Children and Adolescents," in this issue.
- Parental consent challenges: if parents or guardians of transgender children have conflicting opinions about initiating gender-affirming therapy and maintaining medical decision-making power, then it becomes the task of the mental and medical health providers to educate the parents or guardians on the necessity of medical intervention. In the case of transgender youth in the child welfare system, judges are permitted to order medical intervention, including gender-affirming hormone therapy.[3]

Resources

The National Center for Transgender Equality, TransLine: Transgender Medical Consultation Service managed by Project HEALTH, and Lambda Legal maintain updated guidance on federal and state-specific regulations for changing legal identity documents.

SUMMARY

The preventive health care needs of transgender patients differ minimally from the remainder of the population. For this reason, any health care provider with a sensitive approach and proper training can feel confident in caring for this population.

There are several key recommendations that any provider can implement to improve the experience of transgender patients in the health care setting:

- Providers should ensure that the entirety of the patient encounter is adaptable and sensitive to the needs of transgender patients. To this end, clinics should provide staff with sensitivity training and ensure the adaptability of EHRs.
- During the clinical encounter, PCPs should conduct a history and physical examination as they would with any patient, specifically emphasizing considerations of patient privacy, transparency, and cultural sensitivity.
- Review of systems, physical examination, and cancer screenings should be based on a patient's existing anatomy rather than gender identity. In addition to individual patients' risk factors, preventive health discussions should consider the transgender population's increased risk for HIV as well as the influence of gender-affirming hormones on cardiovascular health. Further investigation is required to better understand cancer risks in patients taking gender-affirming hormones.

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- Providers should always maintain LGBTQ+-friendly referral lists in the event that patients need specialized care.
- Finally, health care providers should keep in mind the important role they may play in their patients' legal gender transitions, keeping themselves abreast of major laws and regulations in the state in which they practice.

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Transgender-Competent Health Care: Lessons from the Community

Jesse P. Zatloff, MPH, Silke A. von Esenwein, PhD, Sarah C. Cook, MD, Jason S. Schneider, MD, and J. Sonya Haw, MD

Objectives: Transgender (trans) individuals experience high discrimination levels when accessing medical and mental health care, resulting in poorer health outcomes compared with the general population and other minority populations. A community-based research design was used to elicit direct input from the trans community about critical trans-knowledgeable care components to address these disparities. The data collection included several focus groups with individuals recruited from the trans community. The information from this research guided the opening of the Gender Center, a centralized, multidisciplinary center of care for trans individuals within an urban safety-net hospital in Atlanta, Georgia.

Methods: The research team conducted five focus groups with 27 self-identified trans individuals between December 2016 and April 2017. Focus groups solicited the negative and positive experiences of trans individuals in the healthcare system and sought input about how best to serve this population.

Results: Analysis was done January through April 2020. Focus group participants identified financial difficulties, lack of insurance coverage, being underinsured, discrimination within the healthcare system and from providers, and a shortage of trans-competent providers as the most significant barriers to care. Participants emphasized the need to pay attention to creating a welcoming clinic environment, including trans-positive signage, and integrating trans staff members into the care team.

Conclusions: This study demonstrates the importance of community-based research in addressing health disparities for trans people. It also offers insight into the unmet healthcare needs of the trans community, describes typical healthcare-related experiences of trans individuals, and identifies critical elements for providing high-quality trans-appropriate health care.

Key Words: community-based research, focus groups, health disparities, stigma, transgender health

Transgender (trans) individuals represent 0.3% to 0.6% of the US population, or approximately 1 million people.[1,2] Trans individuals face significant barriers accessing high-quality health care, including primary, mental, and trans-related, or gender-affirming care.[3–5] Trans individuals often are excluded from population and lesbian, gay, bisexual, transgender, and queer (LGBTQ)-based research.[2,6] Even so, there is a body of literature showing significant health disparities and poor health outcomes in trans communities, including a high prevalence of human immunodeficiency virus (HIV),[7,8] substance use disorders,[9] and posttraumatic stress disorder.[10] Although the causes of these disparities are complex,[11,12] experiences of discriminatory and inadequate health care contribute to low utilization and poor health outcomes.[13,14] In particular, research on trans health care in the southern United States demonstrates pronounced health disparities.[15–18] Providers in this geographic area are more likely to refuse care for

Key Points

- Transgender (trans) individuals face severe health disparities and poorer health outcomes compared with the general population as a result of provider discrimination, lack of resources, and a lack of available trans-competent care, among other barriers.
- This study is based on a series of focus groups conducted with transgender individuals to elicit information regarding experiences accessing care, barriers to receiving necessary care, and the unmet needs within the transgender community in Atlanta, Georgia and the metro area.
- These focus groups were conducted as part of a needs assessment led by a team of physicians and public health experts to inform the creation of a centralized, multidisciplinary healthcare center for transgender individuals in metro Atlanta.
- Through collaborative research models between the transgender community and the medical community, the unmet healthcare needs of this vulnerable population can be better understood and the methods the medical community can use to provide high-quality and trans-specific care can be better identified.

From the Departments of Behavioral Sciences and Health Education and Health Policy and Management, Rollins School of Public Health, Emory University, and the Departments of Psychiatry and Behavioral Sciences, Medicine (Division of General Internal Medicine and Geriatrics), and Medicine (Division of Endocrinology, Metabolism, and Lipids), School of Medicine, Emory University, Atlanta, Georgia.

Correspondence to Mr Jesse P. Zatloff, Department of Behavioral Sciences and Health Education, Rollins School of Public Health, Emory University, 1518 Clifton Rd. Atlanta, GA 30322. E-mail: jzatloff@alumni.emory.edu. To purchase a single copy of this article, visit sma.org/smj. To purchase larger reprint quantities, please contact reprintsolutions@wolterskluwer.com.

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trans individuals,[19] and trans individuals living in the US South are less likely to self-disclose their gender identity.[17] This delays the seeking of necessary health services and leads to worse health outcomes.[20]

In 2015, a group of physicians and public health experts affiliated with an urban safety-net hospital in Atlanta, Georgia, began working to provide high-quality trans health care by creating a multidisciplinary clinic (the Gender Center) dedicated to providing comprehensive care for trans patients. Trans individuals make up approximately 0.75% of Georgia's total population, the fourth highest population percentage in the country. This makes Atlanta a "magnet city" for trans individuals living in the southeastern United States and underscores the importance of gender-affirming care in this location.[21] As part of this effort, community input was sought through a series of focus groups with individuals from the local trans community. The data gathered informed the design of the clinic and training of providers and staff. This article summarizes the findings of these focus groups and demonstrates the ability of community-based research models to inform structural change.

Methods

This qualitative study was conducted between December 2016 and April 2017 and included five focus groups with self-identified transgender adults (N = 27). These groups were conducted at the Philip Rush Center, a nonprofit LGBTQ advocacy center and gathering space.[22]

A snowball recruitment method was used[23] through a network of community trans advocacy agencies throughout the Atlanta metro area. This approach was used to reach diversity in income, age, race, ethnicity, and gender. An anonymous, voluntary demographic survey, which had no influence on the ability to participate, was distributed to gauge representativeness and was completed by 13 participants. Each group used the same guide, included 5 to 8 participants, and lasted 60 to 90 minutes. Data collection continued until saturation was reached.[24]

The focus group guide and the subsequent codebook focused on trans individuals' interactions with healthcare systems and both barriers and facilitators of accessing health care to gain a thorough understanding of what should and should not be implemented in the creation of the clinic. Themes centered on healthcare needs, experiences accessing care, financial aspects, attitudes toward mental health care, and opinions about both the clinic and ensuring success.

Two study staff members from Emory University facilitated the focus groups. All of the participants received and documented informed consent and received $25 gift cards for their time. Financial support was received from the Emory Medical Care Foundation. Emory University's institutional review board approved all of the study procedures.

Each group was audio-recorded and transcribed verbatim, followed by an iterative inductive coding process using MAXQDA software (VERBI GmbH, Berlin, Germany). To ensure intercoder reliability, two study staff coded each transcript and compared their process. The study staff who coded received training in qualitative methods and analysis through graduate coursework. They were closely supervised by a faculty member with expertise in qualitative and mixed-methods research and analysis. The coded transcripts were then visually manipulated within the software to best represent the data. A modified grounded theory[24] was used to identify critical relationships in areas significant to the stated research aims.

Results

Of the 13 participants who completed the demographic survey, 77% identified as Black or African American, 62% as (trans) women, with ages ranging from 20 to 41 years. Six main themes were identified from the focus groups: barriers to accessing care, availability of trans-competent providers, inadequacy of healthcare systems for trans patients, institutional barriers, inclusive clinic needs, and demand for mental health services.

Barriers to Access

Being uninsured, underinsured, or having insurance with limited or no coverage for trans-related health services in a state without Medicaid expansion[25] was a commonly reported barrier to healthcare access. One consequence was the use of black market hormones bought online or through social networks:

> *Hi, I'm receiving my hormones from the Netherlands. In my personal experience, I was self-medicating. I was buying black market hormones. I was taking [name of hormone], 40 mL. I don't know what that is exactly, but it's a really strong dose, 40 mL.*

Even with insurance, obtaining coverage for gender-affirming health care often proved challenging. Unclear policies, inconsistent coverage, and draining battles to obtain coverage for necessary care, such as medication, were reported. As two participants shared:

> *What is considered cosmetic and a necessity? A lot of ... a lot of these surgeries that we have to have, they feel like they are cosmetic, "so I'm not going to cover it." Like one, one ... surgeon told me, "Okay, your top is covered but your nipples aren't." And I'm like, "They are a part of me right now, so I don't understand why they are not covered." Because it is considered cosmetic.*

> *I think I ran out 3½ weeks ago and I just couldn't afford to go to the doctor 'cause I'm paying out-of-pocket, so I didn't actually, I wasn't actually able to afford to go back until last week. So, I've gone last week now, and now on this check, this Friday, I'm gonna go get my prescription...*

Another participant discussed common risks and health consequences for trans individuals without healthcare access, particularly for those engaged in sex work or other illegal means of survival. As the following shows, contracting HIV while lacking access to preventive care can paradoxically make individuals eligible for health care and other social services:

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And you know how, girls usually end up getting some kind of help. They end up becoming [HIV] positive, and because they are positive, now they are going to a clinic and there from the clinic they're getting treatment. But all that could have possibly been avoided if they weren't trying to buy black market hormones by prostituting or whatever...

Availability of Trans-Competent Providers

Many participants reported that finding competent providers can be physically, mentally, and financially demanding. Some felt forced to resort to burdensome and potentially risky strategies to safely receive care:

I went 6 hours away to get my hormones. That's why I lived a stealth life. That's why I timed out my hormones. I didn't go on a full dose right off the bat. I went on a quarter of a dose that a dude usually goes on so that I wouldn't have facial hair until I was ready to quit my job and move. So, I lived my nice, comfortable, stealth life out because I planned everything out.

…but it's like, like they said, you kinda gotta navigate … in the system. I wouldn't go to the emergency room; I wouldn't tell any trans person to go to an emergency room. That is not a good thing … I would wait and schedule a regular doctor's appointment; it doesn't matter how bad it got. One time I had a fever of like 107, they told me I shoulda died the night before.

In particular, qualified surgeons were identified as a scarce resource. Having to travel to skilled surgeons presented logistical and financial barriers:

There are not really, in my opinion, good surgeons ... for anyone. You really have to travel, and then it's not covered by insurance, so the affordability for that is ridiculous. And that's a huge thing that holds people back.

Participants talked at length about the expensive, time-consuming process of obtaining letters from psychiatrists or therapists attesting to their psychological preparedness for gender-affirming medical treatment. Many participants shared that few providers were willing to provide letters and that many were unaffordable:

Every doctor I called, 'cause I didn't know about [organization name], told me they wouldn't see me until I got an HRT [hormone replacement therapy] letter. To have a conversation. Not get a prescription. To have a conversation. Won't see me until I have an HRT letter. So, I looked, I called, I called the therapist that we go to group with, none of these people would take my insurance or I couldn't afford them ... [or] they didn't provide HRT letters.

Another participant, discussing the high fees therapists charged, put it succinctly:

You're not an ally to the community if you're charging $160 an hour to someone you know just lost their job because they're trans.

Participants generally talked positively about mental health care and emphasized the need for quality and affordable services in the community:

I felt like if there was mental help, if there was a psychologist that would have been there throughout the process, I would have had more self-esteem now and I would have been happier with myself...

What's really missing is that even if you go to your primary care doctor and get your hormones done or get help started that—what I really missed is ... mental health.

Some raised concerns about mental healthcare providers overemphasizing their trans identity, leaving little room for unrelated issues or concerns. Some reported that therapists often assumed a history of trauma or gender dysphoria, leading participants to feel labeled or misdiagnosed:

I don't need therapy for my gender. I need therapy for things that happened because of my gender but I don't need it for gender.

Healthcare System Barriers

Many participants described their interactions with healthcare systems as profoundly demeaning, often preventing them from seeking future care. Healthcare systems are generally not set up for the needs of trans patients. The lack of inclusion in electronic medical records; patient forms; and absence of continuity among electronic, paper, and verbal communication, often resulted in misgendering, such as improper pronoun usage or using someone's "dead name," a name assigned at birth discarded during or posttransition:

Well, when they misgender you, you already kind of think they, they are not in your corner. Like, I would think they are not taking this as serious…

Another participant spoke of the psychological toll misgendering could have on a patient already stressed by the emotional and physical changes involved in transitioning:

I'm already mentally off because this is happening to me in the first place. You really just messin', jarred me even more by doin' that because I know what I am, I know where I'm goin', I know where I'm headin', and you just called me "mister." It was really … just took me back to somewhere where I never wanted to be in the first place. It's really mentally jarring.

Other Institutional Barriers

Another pervasive theme in the groups was feeling excluded from the healthcare system and health-related community-based organizations, including LGBTQ organizations. This perceived exclusion led to distrust and negativity toward service and advocacy providers who claimed authority or alliance with the trans community or trans health. For many, this exclusion originated

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in the structural aspects of healthcare and other service encounters, including gender-binary intake forms, gender-designated bathrooms, and, on a larger scale, nonprofit and governmental organizations' allocation of funds. As one participant stated:

> *From like my experience with ... healthcare providers [it's] ... it feels like, I always feel like I'm left out, but I don't, I tend to not say anything because, you know, why try to debate, we already know where it's going to go. You know? I'm always going to be made out to seem like something, I'm making something out to be what it really isn't, but it clearly is because it's vivid as daylight, you know what I mean? And it just seems like being an outcast and it's just ... what type of ... motive do you have?*

Another participant spoke about their perception that LGBTQ initiatives and funding often ignore trans issues or concerns and prioritize either HIV/AIDS or gay, cis-gendered men's health:

> *How can I get some of that trans money? It's, it's a lot of it in D.C., and it's not a lot of it being used here. It's gay stuff everywhere, you know, for gay men. It's stuff for HIV and AIDS everywhere.*

Desired Clinic Characteristics

At the end of each focus group, advice and suggestions were elicited for creating a welcoming and useful trans-health clinic. Concerns and suggestions centered on staffing, services, routine mental health evaluations, and physical safety.

Participants stressed the importance of the physical environment and its role in feelings of safety and inclusion. One participant pointed out potential privacy and safety issues if there were signage indicating the presence and location of a trans clinic:

> *But, to have signage outside, I think would not be a smart thing. And I think that would be a turn off for me or for anybody else who had already been past that decision-making point, because you, you already know that, but the people who are still tryin' to make those decisions or people who are tryin' to do it without everybody knowing their business, can put them in danger. It can put even us in danger.*

Another central concern was that all of the paperwork and signage be affirmative and inclusive, avoiding any misgendering. Participants also felt apprehensive about HIV-related advertisements and posters and the ubiquitous open availability of condoms that dominate LGBTQ-related healthcare settings. Participants associated these with common stereotypes of promiscuity and hypersexuality:

> *Something that's not really trans-friendly, and just all, in all LGBT friendly, period ... are, as soon as you walk into the clinic, all you see is HIV signs.*

> *What place have you been into, into a regular doctor's office, where people take their little kids, and walk in, as soon as you hit that door, there's a bucket full of condoms? No, that's not friendly. That's like saying, "everybody in that, in the trans community, everybody that's LGBT associated...you have sex a lot. You don't know; you don't buy protection, you don't wear protection, so we're off, we have it right here for you." Soon as you walk in the door, maybe you're gonna have sex in here.*

Participants spent a significant amount of time discussing the importance of sensitivity training for staff, including staff at registration, medical technicians, nurses, and physicians. It was emphasized that the whole care team needed to be competent and knowledgeable about the needs and specific vulnerabilities of trans patients. In addition, hiring trans staff members was considered essential, as was having an ongoing mechanism to receive feedback from patients and the community.

Mental Health Service Needs

The participants felt strongly that mental health care was needed in the community. Once the idea of "mental health evaluations" was raised, however, participants immediately voiced suspicions about their purpose and motivation. Based on previous adverse encounters, many participants feared that psychological screens may be used to pathologize trans individuals further or as "gatekeeping" mechanisms to accessing health care. As one participant asserted, with the group's agreement:

> *But if you told me that the only way that I could get care at your clinic is if I went to this mental screening, I would tell you, "No. Thanks. Bye."*

Once it was made clear that evaluations would not be required to receive care, the conversation around having mental healthcare services available became positive and overwhelmingly supportive.

Discussion

Focus groups were conducted to identify and describe barriers and facilitators to trans-competent health care of trans individuals in the Atlanta metro area. The collected data informed a multidisciplinary clinic's structure and practices for trans patients within a large urban safety-net hospital system. The most reported healthcare barriers were lack of qualified providers, particularly surgeons, and financial and insurance limitations. Most participants had experienced negative and often traumatizing healthcare experiences, ranging from improper pronoun usage to incompetent, disrespectful, or abusive care. Improved access to high-quality health care and training for providers was at the center of the group discussions. Finally, it was emphasized that a clinic located in the US South, in a predominantly African American urban setting, must address the entrenched racial, ethnic, and political divides that exacerbate the vulnerability of the trans population and discourage health-seeking behaviors.[15,16]

When discussing the prospect of a transgender clinic, the consensus was that for it to be successful, it must do the

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following: train staff extensively in trans-related issues, include trans staff, offer quality mental health care, and continue to collaborate with the community. Given the current barriers to care and often traumatic histories with providers and healthcare systems, training is critical to providing appropriate care while building the necessary trust among the clinic, patients, and the broader trans community. These conclusions are consistent with the literature on efforts to integrate trans health care into primary care settings effectively.[26,27]

The strengths of this study are its diversity of experiences and perspectives and its strong emphasis on applied community-based research. The limitations are that, although the recruiting method theoretically allowed for a diverse group of participants, selection bias may have attracted participants who were not representative of the broader trans community's experiences and demographic makeup. The relatively small sample size, study design, and the location's particular characteristics may have limited generalizability. We, however, believe that, although regional characteristics may vary, the underlying themes identified in this article reflect considerations relevant to any trans healthcare provider.

Conclusions

There is little guidance for healthcare systems and providers on how to provide effective and culturally proficient health care to trans individuals. This study provides a detailed account of the healthcare-related experiences of trans individuals. It also includes information on how best to provide high-quality care, including trans representation among staff, an opt-in mental health services model, a safe physical space, and targeted training for all of its providers and staff. Ultimately, this study underscores the necessity of community-based research models, demonstrating how fostering and strengthening the relation between medical and transgender communities can move us one step closer to health equity.

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Prevention-effective adherence trajectories among transgender women indicated for PrEP in the United States: a prospective cohort study

Erin E. Cooney, MSPH[a,*], Sari L. Reisner, ScD[b,c,d,e], Haneefa T. Saleem, PhD[a], Keri N. Althoff, PhD[f], S. Wilson Beckham, PhD[a,g], Asa Radix, MD[h], Christopher M. Cannon, MPH[i], Jason S. Schneider, MD[j], J. Sonya Haw, MD[j], Allan E. Rodriguez, MD[k], Andrew J. Wawrzyniak, PhD[l], Tonia C. Poteat, PhD[m], Kenneth H. Mayer, MD[b,d], Chris Beyrer, MD[f], Andrea L. Wirtz, PhD[f], American Cohort To Study HIV Acquisition Among Transgender Women (LITE) Study Group

[a] *Johns Hopkins Bloomberg School of Public Health, Department of International Health, Baltimore, MD*
[b] *Fenway Health, The Fenway Institute, Boston, MA*
[c] *Brigham and Women's Hospital, Division of Endocrinology, Diabetes, and Hypertension, Boston, MA*
[d] *Harvard Medical School, Department of Medicine, Boston, MA*
[e] *Harvard TH Chan School of Public Health, Department of Epidemiology, Boston, MA*
[f] *Johns Hopkins Bloomberg School of Public Health, Department of Epidemiology, Baltimore, MD*
[g] *Johns Hopkins Bloomberg School of Public Health, Department of Health, Behavior and Society, Baltimore, MD*
[h] *Callen-Lorde Community Health Center, New York, NY*
[i] *Whitman-Walker Institute, Washington, DC*
[j] *Emory University, School of Medicine, Atlanta, GA*
[k] *University of Miami Miller School of Medicine, Division of Infectious Diseases, Department of Medicine, Miami, FL*
[l] *University of Miami Miller School of Medicine, Department of Psychiatry and Behavioral Sciences, Miami, FL*
[m] *University of North Carolina School of Medicine, Center for Health Equity Research, Chapel Hill, NC*

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ABSTRACT

Purpose: Adherence to pre-exposure prophylaxis (PrEP) during periods of PrEP-indication (i.e., prevention-effective adherence) is critical for preventing HIV. We sought to describe factors associated with prevention-effective adherence trajectories among transgender women (TW) to inform PrEP implementation strategies.

Methods: Using data from The LITE American Cohort (n = 728), we performed group-based multi-trajectory modeling (GBMTM) to identify clusters of TW with similar trajectories of PrEP adherence and indication, and sociodemographic, biobehavioral, and structural correlates of each trajectory.

Results: We identified five trajectories: (1) consistent indication/no PrEP (15.3%), (2) initial indication/no PrEP (47.1%), (3) declining indication/discontinued PrEP (9.5%), (4) consistent indication/PrEP adherent (18.5%), and (5) increasing indication/initiated PrEP (9.6%). TW diagnosed with an STI were more likely to follow a consistent indication/no PrEP trajectory compared to consistent indication/PrEP adherent trajectory (adjusted Relative Risk Ratio [aRRR], 2.54; 95% confidence interval [CI], 1.16–5.57). TW who experienced homelessness were more likely to follow PrEP discontinuation and initiation trajectories relative to PrEP adherence (aRRR, 2.71; 95% CI, 1.10–6.70 and 2.83; 95% CI, 1.13–7.05, respectively).

Conclusions: Over a quarter of TW followed trajectories suggestive of prevention-effective adherence, while 15% did not initiate PrEP despite consistent indication. Findings highlight missed opportunities for

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* Corresponding author. Department of International Health, Bloomberg School of Public Health, Johns Hopkins University, 615 N. Wolfe St, Office E5035, Baltimore, MD 21205. Tel.:+1 401-595-3436

E-mail address: Ecooney2@jhmi.edu (E.E. Cooney).

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PrEP engagement at STI diagnosis and suggest structural interventions addressing housing instability may improve prevention-effective adherence among TW.

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Introduction

Globally, transgender women (TW) are highly impacted by the HIV epidemic, with prevalence estimated at 19% [1]. In the United States (US), approximately 14% of TW are living with HIV, with over half of new diagnoses occurring among TW in the South [2,3]. Due to intersecting systems of oppression (e.g., racism, transphobia, and xenophobia), 90% of incident infections are diagnosed among TW of color leading to HIV prevalence estimates of 44%–62% and 26%–35% among Black and Latina TW, respectively [2,3].

Despite the established need for multilevel interventions to prevent HIV among TW, a recent review of HIV prevention interventions designed or adapted for transgender people identified only 13 evidence-based interventions, 11 of which were behavioral [4]. The only evidence-based biomedical prevention intervention currently approved in the US for TW is pre-exposure prophylaxis (PrEP). However, the sole study reporting PrEP efficacy data specifically for TW, a subgroup intention-to-treat analysis of the iPrEx trial, found PrEP did not reduce HIV acquisition risk among TW due to suboptimal adherence [5].

Qualitative research has described homelessness, lack of insurance coverage, discrimination in healthcare, violence, and other sociostructural factors as barriers to PrEP initiation and adherence among TW [6–8]. The higher burden of discrimination and social and economic marginalization among Black and Latina TW suggests that the groups most likely to benefit from PrEP also have the highest barriers, with the potential to reinforce existing HIV disparities if inequities in PrEP access are not directly addressed [9].

A recent review of literature on PrEP outcomes in cisgender and transgender women in the United States found just six studies with samples comprised exclusively of TW [10]. An additional 40 studies included TW alongside other populations (predominately cisgender men who have sex with men), but the majority reported no findings specific to TW [10]. One study utilizing PrEP programmatic data from a hospital-based PrEP clinic in Atlanta (N = 42) reported 62% of TW who initiated PrEP persisted in care at 6 months post-referral [11]. The use of programmatic data prevented authors from ascertaining changes in PrEP indication; thus it was assumed that TW initially prescribed PrEP had consistent PrEP indication, which does not account for time-varying HIV risk [12]. Other studies have reported suboptimal PrEP uptake [13,14], adherence [5,15–17], and persistence [18] among TW, but many had small sample sizes, short follow-up periods, failed to account for time-varying PrEP-indication, or reported on data from clinical trials, which make the generalizability of these findings to real-world settings unclear [19]. Thus, there is a dearth of information on quantitative, longitudinal PrEP engagement outcomes among TW to guide public health interventions. Given the promise of PrEP for preventing HIV in TW alongside evidence of suboptimal engagement in the PrEP continuum, there is a need for differentiated implementation strategies for this population [16,20,21].

One challenge of defining PrEP adherence targets for populations at increased risk for HIV acquisition (e.g., TW), is the need to consider time-varying HIV-risk [12]. As Haberer and colleagues note, the adherence paradigm for HIV treatment is not appropriate for PrEP; unlike antiretrovirals for HIV treatment, which require sustained, lifelong adherence to achieve desired health outcomes, PrEP is effective so long as adherence is high during periods of exposure not protected by other effective strategies (e.g., condoms) [12]. Further, PrEP use during periods of non-indication may be associated with costs to the individual (e.g., unnecessary side effects) and health system (e.g., resource costs). Haberer and colleagues propose an alternative paradigm for understanding and measuring PrEP adherence, termed “prevention-effective adherence” [12]. Following Haberer’s conceptualization of prevention-effective adherence, which measures PrEP adherence alongside dynamic sociobehavioral HIV risk indicators (i.e., PrEP indication), we sought to describe the distribution and correlates of prevention-effective adherence trajectories over 18 months among a large, multisite cohort of TW [12].

Methods

Study design and participants

The LITE study is a multisite, technology-enhanced epidemiologic cohort examining multi-level risks for HIV acquisition and other health outcomes among adult TW in the United States. TW (assigned male sex at birth and identify as women or feminine gender identity) who are ≥18 years old, fluent in English and/or Spanish, and reside in the Eastern and Southern US are eligible. LITE is comprised of a site-based arm (with annual facility-based visits and the option of facility-based or remote visits for the interim, quarterly timepoints) and a fully remote arm (with semi-annual remote visits). Visits include sociobehavioral surveys and HIV testing, with site-based participants receiving annual testing for bacterial sexually transmitted infections (STIs; syphilis, gonorrhea, and chlamydia). Survey domains include sociodemographics, gender-affirming experiences, general physical and mental health, PrEP engagement, substance use, sexual health, and experiences of discrimination and violence. Due to a staggered launch and differences in visit frequency, the present analysis is restricted to site-based participants, who reside in six cities: Atlanta, GA; Baltimore, MD; Boston, MA; Miami, FL; New York, NY; and Washington, DC. Detailed study procedures, including recruitment strategies and sample size calculations, are available in published protocols [22,23]. All study procedures were approved by the Johns Hopkins School of Medicine Institutional Review Board (IRB). Written informed consent was obtained from all participants prior to enrollment.

Data sources and definitions

Surveys were self-administered; however, participants who screened positive for low literacy, needed assistance using the tablet, or requested a research assistant read questions aloud in their preferred language were provided that option. Data from the first seven quarterly time-points (i.e., baseline through 18 months of enrollment) were used in this analysis. Static indicators (e.g., race and ethnicity) were ascertained at baseline, while time-varying indicators (e.g., recent homelessness) were assessed quarterly.

The following self-reported measures from baseline were included in this analysis: age (dichotomized as 18–24 and ≥25 years

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old); race (Black or African American vs. not Black or African American); ethnicity (Latina or Hispanic vs. not Latina or Hispanic); census division (New England, Mid-Atlantic, and South Atlantic); education (high school education or less vs. some college or more); time since last healthcare encounter (within the last 6 months vs. ≥6 months); and anticipated discrimination in healthcare (determined by agreement with the statement "Because of who I am, a doctor or other healthcare provider might treat me poorly" from the Intersectional Discrimination Index-A) [24]. The following time-varying variables—homelessness, arrest by police, uninsured health insurance status, and current partner PrEP use—were dichotomized as "1" if a participant reported the experience during at least one of seven study visits versus "0" otherwise. We identified incident STIs through laboratory-confirmed testing at baseline and 12-month follow-up as described in the study protocol [23].

The first outcome, PrEP adherence, indicates the number of reported PrEP doses taken in the last seven days and ranged from 0 (no PrEP use) to 7 (daily adherence). All participants who indicated they were not currently taking PrEP were coded 0. TW reporting current PrEP use were asked, "In the past 7 days, how many days have you missed taking a dose of PrEP?" This item was inverse coded so that TW reporting 0 missed doses were assigned an adherence value of 7, those reporting 1 missed dose were coded as 6, etc.

The second outcome, PrEP indication, is a composite variable based on current CDC PrEP prescribing guidelines, which we have previously adapted for TW [25]. Although PrEP indication is not a perfectly sensitive indicator of HIV acquisition risk, it is a widely used metric to distinguish those at elevated risk of HIV acquisition, and important for characterizing risk heterogeneity within key populations. TW were indicated for PrEP if they had biologically-confirmed HIV-negative serostatus, a sex partner with flesh penis within the past 6 months, were not in a monogamous sexual partnership with an HIV-negative partner, and reported at least one of the following recent indicators (i.e., within past 3 months): (a) condomless anal sex, (b) STI diagnosis, (c) sex work, (d) use of post-exposure prophylaxis, (e) condomless anal or vaginal sex with a partner living with HIV or of unknown HIV status, and (f) needle sharing. This outcome was dichotomized as PrEP-indicated or not PrEP-indicated at each visit.

Statistical analysis

We calculated the proportion of TW indicated for PrEP and the proportion using PrEP at any visit over follow-up. After restricting the analytic sample to only those who were either PrEP-indicated and/or using PrEP during at least one visit, we performed group-based multi-trajectory modeling (GBMTM), a data-driven approach for identifying latent longitudinal strata across distinct but related indicators, to determine whether there were distinctive patterns of prevention-effective adherence [26]. Following the model selection process set forth by Nagin, we explored specific patterns in each of the outcomes (PrEP adherence and indication) individually before modeling the joint outcome [26]. Model selection and adequacy was assessed following Nagin's diagnostic criteria (see Supplementary file) [27].

Following specification of the final model, we explored sociodemographic, biobehavioral, and structural indicators by group. We used multinomial logistic regression to identify correlates of trajectory groups. Predictors of group membership that were statistically significant at $P < .10$ in bivariate analyses were included in the final multivariable model, which also included race, ethnicity, and census division. All variables had missingness ≤5%, thus we did not impute missing values. As a sensitivity analysis to assess for statistically significant changes in prep use and indication during the COVID-19 pandemic, we conducted interrupted time series analysis, accounting for secular trends. Analyses were conducted using Stata version 14, including the traj package for GBMTM specification [28].

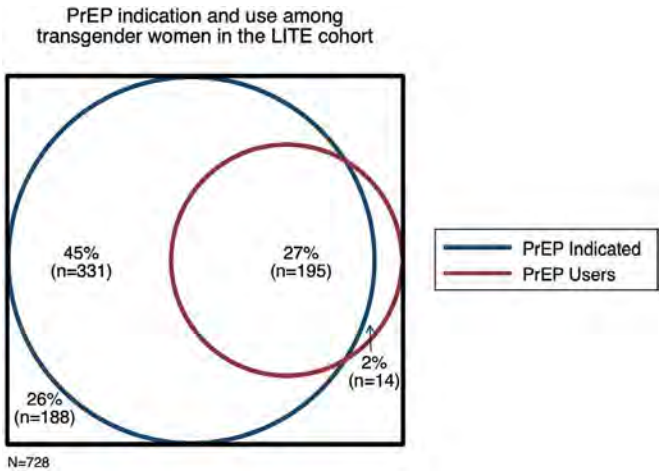

Fig. 1. PrEP indication and use among transgender women in the LITE cohort. Note: Figure 1 represents the full study sample (N = 728). Subsequent analyses (i.e., those reported in Table 2 and Figure 2) were restricted to participants who were PrEP indicated and/or PrEP users (n = 540; represented by blue and/or maroon circles). Characteristics of those not enclosed in either circle and thus excluded from additional analyses (i.e., those never indicated for nor using PrEP; n = 188) are summarized in Table 1 (see Group 0).

Results

We enrolled 728 TW between March 2018 and August 2020, of whom 526/728 (72.3%) were indicated for PrEP within 18 months of enrollment. Among Latina and Black TW, 88.4% (168/190) and 87.7% (206/235) were indicated for PrEP within 18 months of enrollment, respectively. The majority of those who were PrEP-indicated reported no PrEP use over follow up (62.9%; 331/526). Over the same period, 209 of 728 (28.7%) self-reported PrEP use, 14 of whom were not PrEP-indicated (Fig. 1). The remaining 188 of 728 (25.8%) were neither PrEP-indicated nor using PrEP at any time over follow-up. This group was predominately non-Black, non-Latina, college-educated, engaged in healthcare, and had health insurance (Table 1). Thus 540 participants were PrEP-indicated and/or reported taking PrEP at least once during 18 months of follow-up and were therefore included in subsequent group-based multi-trajectory modeling.

We identified five prevention-effective adherence trajectories, classified as (1) consistent indication/no PrEP (15.3%; 95% confidence interval [CI], 11.3–19.3), (2) initial indication/no PrEP (47.1%; 95% CI, 42.1%–52.1%), (3) declining indication/discontinued PrEP (9.5%; 95% CI, 6.8%–12.5%), (4) consistent indication/PrEP adherent (18.5%; 95% CI, 15.0%–22.0%), and (5) increasing indication/initiated PrEP (9.6%; 95% CI, 7.0%–12.2%). This five-group multi-trajectory model exceeded *a priori* criteria for model adequacy (Supplementary file).

Declining indication/discontinued PrEP and consistent indication/PrEP adherent trajectories were characterized by strong concordance between indication and adherence, though adherence was suboptimal during periods of indication for both groups (Fig. 2). The remaining three groups were marked by periods of PrEP indication and non-use (i.e., nonprevention-effective adherence). The first group, consistent indication/no PrEP, demonstrated non-prevention-effective adherence over the entire follow-up.

Sociodemographic, clinical, and structural characteristics of each trajectory group are compared in Table 1. The majority of TW assigned to the consistent indication/no PrEP trajectory (58.4%)

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Table 1
Sociodemographic, clinical, and structural characteristics of transgender women in the LITE cohort by prevention-effective adherence trajectory (N = 728)

Factor n	Full sample 728 n (%)	Group 0: Never indicated/no PrEP 188 n (%)	Group 1: Consistent indication/ no PrEP 77 n (%)	Group 2: Initial indication/ no PrEP 263 n (%)	Group 3: Declining indication/discontinued PrEP 52 n (%)	Group 4: Consistent indication/PrEP adherent 99 n (%)	Group 5: Increasing indication/ initiated PrEP 49 n (%)	*P*-value (χ^2 test)
Youth (Aged 18–24)	214 (29.4)	43 (22.9)	16 (20.8)	103 (39.2)	16 (30.8)	18 (18.2)	18 (36.7)	<.001
Black	235 (32.6)	29 (15.7)	30 (39.0)	88 (33.7)	23 (45.1)	39 (39.4)	26 (55.3)	<.001
Latina	190 (26.5)	22 (11.8)	23 (29.9)	78 (30.5)	18 (36.7)	35 (35.4)	14 (29.2)	<.001
Census division								<.001
New England	158 (21.7)	63 (33.5)	11 (14.3)	55 (20.9)	8 (15.4)	13 (13.1)	8 (16.3)	
Mid-Atlantic	221 (30.4)	47 (25.0)	21 (27.3)	86 (32.7)	22 (42.3)	31 (31.3)	14 (28.6)	
South Atlantic	349 (47.9)	78 (41.5)	45 (58.4)	122 (46.4)	22 (42.3)	55 (55.6)	27 (55.1)	
College education or higher	464 (64.4)	141 (75.0)	45 (58.4)	164 (63.1)	20 (39.2)	69 (71.1)	25 (52.1)	<.001
Homelessness*	163 (22.5)	23 (12.3)	20 (26.0)	67 (25.6)	19 (36.5)	17 (17.2)	17 (34.7)	<.001
Arrest*	42 (5.8)	2 (1.1)	10 (13.0)	17 (6.5)	2 (4.0)	5 (5.1)	6 (12.2)	<.01
Uninsured*	80 (11.6)	16 (8.7)	15 (19.7)	31 (12.8)	4 (7.8)	8 (8.9)	6 (13.0)	.15
Lab-confirmed STI*	102 (14.0)	0 (0.0)	30 (39.0)	27 (10.3)	12 (23.1)	21 (21.2)	12 (24.5)	<0.001
One or more current partner(s) using PrEP*	215 (29.7)	18 (9.7)	22 (28.6)	61 (23.3)	26 (51.0)	61 (61.6)	27 (55.1)	<.001
Six months or longer since last healthcare encounter	53 (7.4)	10 (5.4)	13 (17.1)	19 (7.3)	2 (3.8)	4 (4.0)	5 (10.2)	.01
Anticipated discrimination in healthcare	301 (42.2)	90 (47.9)	31 (40.8)	103 (40.7)	21 (42.0)	43 (43.4)	13 (27.7)	.23

* At any point over follow-up. All other indicators were assessed at baseline only.

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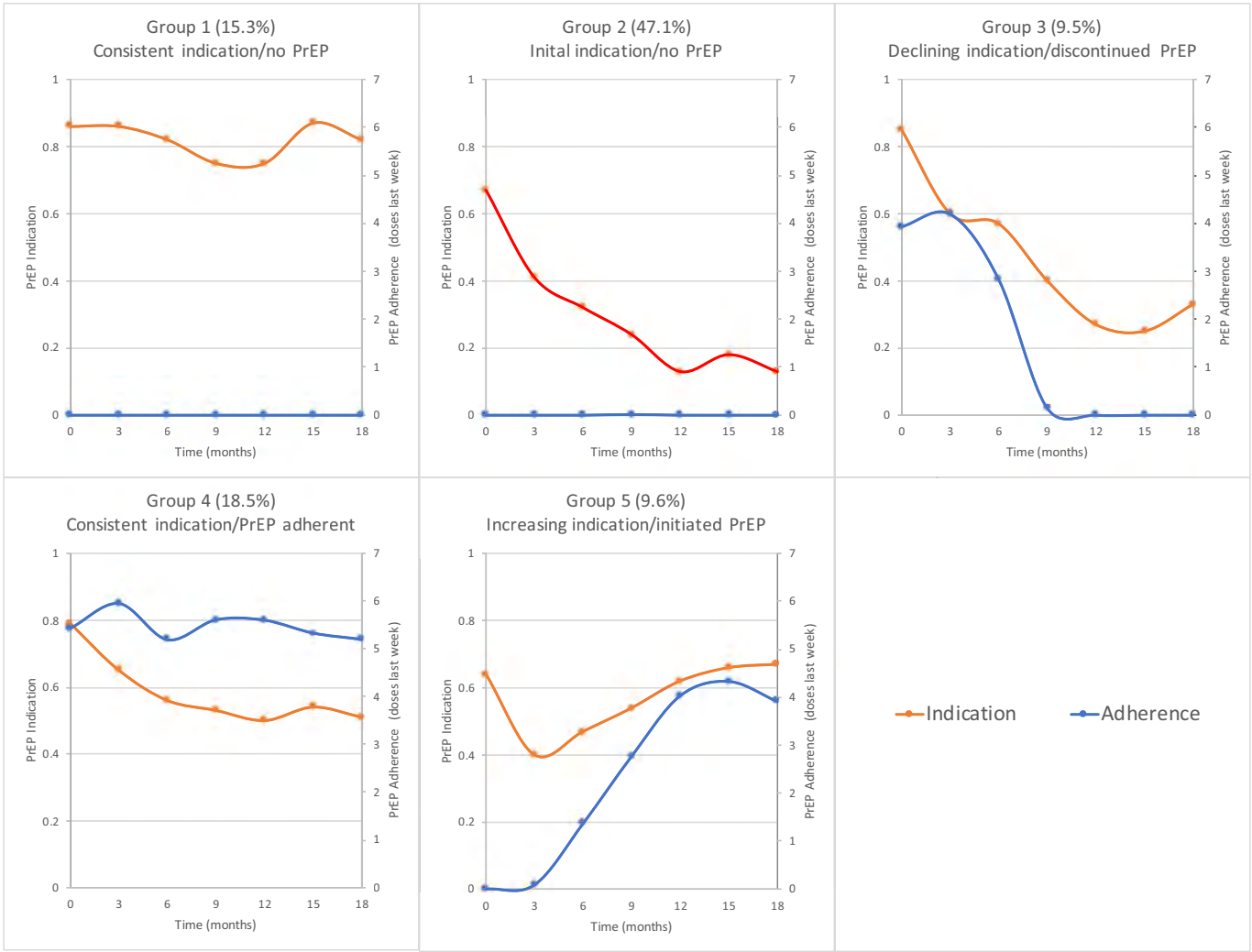

Fig. 2. Prevention-effective adherence trajectories among transgender women in the LITE cohort (N = 540).

resided in the South. This group had the highest proportion of uninsured TW (19.7%), STI diagnosis over follow-up (39.0%), and disengagement from healthcare at enrollment (17.1%). The modal trajectory, initial indication/no PrEP, was largely comprised of young (39.2%) and college-educated (63.1%) TW. Apart from the never indicated/no PrEP trajectory, this group had the lowest STI period prevalence (10.3%). TW with declining indication/discontinued PrEP trajectories were predominately TW of color (45.1% Black and 36.7% Latina), least likely to be college-educated (39.2%), and most likely to report homelessness over follow-up (36.5%). The majority of TW with consistent indication/PrEP adherent trajectories were ≥25 years old (81.8%), college-educated (71.1%), and reported at least one partner using PrEP over follow-up (61.6%). Finally, the majority of TW with increasing indication/initiated PrEP trajectories was Black (55.3%), college-educated (52.1%), and resided in the South (55.1%). This group also had the lowest proportion of anticipated discrimination in healthcare (27.7%).

Table 2 reports unadjusted and adjusted relative risk ratios (aRRR) from multinomial logistic regression models to identify correlates of trajectory group membership. The reference group for all pairwise comparisons is the consistent indication/PrEP adherent group. Participants with an STI diagnosis over follow-up and those who had not had a healthcare encounter within 6 months of enrollment were more likely to follow a consistent indication/no PrEP trajectory (aRRR, 2.54; 95% CI, 1.16–5.57 and aRRR, 5.66; 95% CI, 1.40–22.85, respectively). Participants reporting one or more PrEP-using partner(s) were significantly less likely to follow a consistent indication/no PrEP trajectory (aRRR, 0.18; 95% CI, 0.09–0.36). Those aged 18–24 were more than three times as likely to follow an initial indication/no PrEP trajectory (aRRR, 3.04; 95% CI, 1.60–5.78). Finally, experiencing homelessness over follow-up was associated with significantly greater relative risk of membership in declining indication/discontinued PrEP and increasing indication/initiated PrEP trajectories (aRRR, 2.71; 95% CI, 1.10–6.70 and 2.83; 95% CI, 1.13–7.05, respectively). In our sensitivity analysis, there was not a statistically significant difference in PrEP indication or use during the COVID-19 pandemic after accounting for secular trends (Supplementary file).

Discussion

Available evidence, though limited, has raised concerns regarding suboptimal engagement in PrEP care among transgender women [5,11, 13–18]. Operationalizing Haberer's prevention-effective adherence paradigm, we aimed to describe the distribution of prevention-effective adherence trajectories over an 18-month period among a large observational sample of TW [12]. We

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Table 2
Relative risk ratios (RRR) for prevention-effective adherence trajectory among transgender women indicated for and/or using PrEP in the LITE cohort (N = 540)

	Unadjusted relative risk ratios				Adjusted relative risk ratios			
Reference group: Group 4: Consistent indication/PrEP adherent	RRR	*P*-value	95% CI		aRRR	*P*-value	95% CI	
Group 1: Consistent indication/no PrEP								
Youth (Aged 18–24)	1.18	.67	0.56	2.5	1.18	.69	0.52	2.66
Black	0.98	.95	0.53	1.81	0.62	.25	0.28	1.40
Latina	0.78	.44	0.41	1.48	0.47	.06	0.21	1.04
Census division (ref = New England)								
Mid-Atlantic	0.80	.66	0.30	2.12	0.92	.88	0.31	2.69
South Atlantic	0.97	.94	0.40	2.36	1.02	.96	0.37	2.86
College education or higher (ref = high school diploma/GED or less)	0.57	.08	0.30	1.07	0.63	.22	0.30	1.31
Homelessness*	1.69	.16	0.82	3.51	2.07	.09	0.88	4.82
Arrest*	2.81	.07	0.92	8.59	2.56	.16	0.69	9.52
Uninsured*	**2.52**	**.05**	1.00	6.32	1.47	.48	0.51	4.24
Lab-confirmed STI*	**2.37**	**0.01**	1.22	4.61	**2.54**	**.02**	1.16	5.57
1 or more current partner using PrEP*	**0.25**	**<.001**	0.13	0.47	**0.18**	**<.001**	0.09	0.36
6+ months since last healthcare encounter	**4.90**	**<.01**	1.53	15.71	**5.66**	**.02**	1.40	22.85
Anticipated discrimination in healthcare	0.90	.73	0.49	1.64	1.02	.95	0.50	2.07
Group 2: Initial indication/no PrEP								
Youth (Aged 18–24)	**2.90**	**<.001**	1.64	5.11	**3.04**	**<.001**	1.60	5.78
Black	0.78	.32	0.49	1.26	0.62	.14	0.33	1.17
Latina	0.80	.38	0.49	1.31	0.71	.27	0.39	1.30
Census division (ref = New England)								
Mid-Atlantic	0.66	.26	0.32	1.36	0.73	.45	0.32	1.67
South Atlantic	0.52	.06	0.26	1.04	0.8	.58	0.36	1.78
College education or higher (ref = high school diploma/GED or less)	0.69	.16	0.42	1.15	0.9	.75	0.49	1.67
Homelessness*	1.66	.09	0.92	2.99	1.87	.10	0.89	3.94
Arrest*	1.31	.61	0.47	3.65	1.03	.97	0.28	3.81
Uninsured*	1.50	.33	0.66	3.4	1.52	.38	0.59	3.91
Lab-confirmed STI*	**0.43**	**<.01**	0.23	0.8	**0.45**	**.03**	0.21	0.94
1 or more current partner using PrEP*	**0.19**	**<.001**	0.12	0.31	**0.15**	**<.001**	0.09	0.27
6+ months since last healthcare encounter	1.88	0.26	0.62	5.67	2.1	.29	0.54	8.21
Anticipated discrimination in healthcare	0.89	0.64	0.56	1.43	0.83	0.51	0.46	1.47
Group 3: Declining indication/discontinued PrEP								
Youth (Aged 18–24)	2.00	.08	0.92	4.36	1.48	.38	0.62	3.56
Black	1.26	.50	0.64	2.50	0.81	.63	0.34	1.93
Latina	1.06	.87	0.52	2.16	0.82	.64	0.36	1.88
Census division (ref = New England)								
Mid-Atlantic	1.15	.79	0.41	3.25	1.32	.64	0.41	4.23
South Atlantic	0.65	.40	0.24	1.78	0.88	.83	0.28	2.80
College education or higher (ref = high school diploma/GED or less)	**0.26**	**<.001**	0.13	0.53	**0.28**	**<.01**	0.13	0.63
Homelessness*	**2.78**	**<.01**	1.29	5.99	**2.71**	**.03**	1.10	6.70
Arrest*	0.78	.78	0.15	4.19	0.91	.92	0.15	5.62
Uninsured*	0.87	.83	0.25	3.05	0.76	.69	0.20	2.93
Lab-confirmed STI*	1.11	.79	0.5	2.49	1.03	.95	0.41	2.60
1 or more current partner using PrEP*	0.65	.21	0.33	1.28	0.59	.18	0.28	1.27
6+ months since last healthcare encounter	0.95	.95	0.17	5.37	1.79	.54	0.27	11.8
Anticipated discrimination in healthcare	0.94	.87	0.47	1.88	1.01	.98	0.46	2.23
Group 5: Increasing indication/initiated PrEP								
Youth (Aged 18–24 at enrollment)	**2.61**	**.02**	1.21	5.66	2.15	.09	0.90	5.15
Black	1.90	.07	0.94	3.84	1.5	.37	0.62	3.66
Latina	0.75	.46	0.36	1.59	0.64	.33	0.26	1.56
Census division (ref = New England)								
Mid-Atlantic	0.73	.58	0.25	2.17	0.81	.74	0.24	2.80
South Atlantic	0.80	.66	0.3	2.16	0.88	.84	0.27	2.91
College education or higher (ref = high school diploma/GED or less)	**0.44**	**.03**	0.22	0.9	0.65	.31	0.28	1.49
Homelessness*	**2.56**	**.02**	1.17	5.63	**2.83**	**.03**	1.13	7.05
Arrest*	2.62	.13	0.76	9.07	1.99	.38	0.43	9.17
Uninsured*	1.54	.45	0.5	4.73	1.25	.72	0.36	4.32
Lab-confirmed STI*	1.20	.65	0.54	2.71	0.71	.49	0.27	1.87
1 or more current partner using PrEP*	0.76	.45	0.38	1.53	0.78	.53	0.35	1.72
6+ months since last healthcare encounter	2.70	.15	0.69	10.54	3.44	.14	0.67	17.52
Anticipated discrimination in healthcare	0.50	.07	0.23	1.06	0.51	.13	0.21	1.23

Boldface indicates statistical significance at $p<0.05$.
* At any point over follow-up. All other indicators were assessed at baseline only.

found that just over one in four TW at risk for HIV demonstrated patterns of prevention-effective adherence, adhering to PrEP during periods of indication and discontinuing PrEP when no longer indicated. Further, less than 10% initiated PrEP. We estimate that 15% of TW remain unengaged in PrEP services despite consistent indication for PrEP—pointing to an urgent need for tailored PrEP implementation strategies to meet the needs of this subset of TW. Importantly, LITE study locations either have gender-affirming PrEP providers on-site or facilitate referrals to gender-affirming PrEP providers for TW who are interested. Thus, our study population likely has greater access to PrEP care relative to TW broadly–and yet multilevel barriers to engagement [6–9] resulted in a substantial subset of TW underutilizing PrEP.

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Our joint modeling of PrEP adherence and indication supports Haberer's conceptualization of prevention-effective adherence by illustrating both periods of discordance and concordance. As additional PrEP delivery methods become available (e.g., bimonthly injections, yearly implants, and event-driven microbicides), there will be greater opportunity to align PrEP indication and adherence to ensure adequate preventative coverage for concentrated periods of indication (e.g., single events) or prolonged periods of heterogenous risk. Future research should explore how these forthcoming delivery methods will address the unmet prevention needs of TW.

Sociodemographic correlates of trajectory group align with epidemiologic evidence demonstrating concentrated HIV acquisition risk and reduced PrEP accessibility among young, Black, and Latina TW [3,29]. We found that youth are overrepresented in the initial indication/no PrEP and increasing indication/initiated PrEP groups and underrepresented in the consistent indication/PrEP adherent group. This highlights that PrEP indication and adherence are dynamic among young TW and suggests event-driven and/or long-acting options may be more appropriate modalities for youth. Given that HIV prevalence among TW aged 25–29 is nearly four times higher than prevalence among TW aged 18–24, interventions that optimize prevention-effective adherence during this life stage are critical [3].

Black participants comprised over half of those who initiated PrEP. However, to address the inequities in new HIV diagnoses among Black TW, efforts to further increase access and support adherence (e.g., transportation support, telemedicine scale-up, provision of housing services, peer navigation programs, expanding access through community pharmacies) among Black TW are needed [3]. Latina participants comprised a third of PrEP indicated TW and were relatively evenly distributed among trajectory groups. Notably, 87.7% and 88.4% of Black and Latina TW (respectively) were indicated for PrEP compared to 72.3% of the overall sample, demonstrating the importance of PrEP programming that is acceptable and accessible for Black and Latina TW.

Experiences of homelessness were prevalent across groups. TW who experienced homelessness were more than twice as likely to follow trajectories of discontinuation and initiation compared to consistent indication/PrEP adherence. Although further research is warranted to explore the mechanisms by which housing stability impacts prevention-effective adherence, findings point to housing as an important predictor of longitudinal PrEP engagement. TW lacking health insurance were overrepresented in the consistent indication/no PrEP group, which suggests lack of health insurance may be an important barrier. Policies and programs such as Medicaid expansion and low-cost care provision through Federally Qualified Health Centers may increase PrEP engagement.

We found high rates of arrest in our sample (5.8%), with sex work as the most common reason for arrest. A significantly higher proportion of TW reported recent arrest in the consistent indication/no PrEP and increasing indication/initiated PrEP groups (13.0% and 12.2%, respectively). Risk of arrest and HIV vulnerability share common drivers including discrimination, violence victimization, poor mental health, and poverty; policy interventions and human rights centered approaches have the potential to address these drivers, which disproportionately impact Black and Latina TW [30]. As arrest and incarceration can lead to medication lapses, long-acting PrEP formulations may increase prevention-effective adherence among communities disproportionately impacted by over-policing and mass incarceration.

STIs were prevalent in all groups but were more than twice as common in the consistent indication/no PrEP group, which demonstrates that condomless sex is prevalent and PrEP need remains high. TW in this group are likely to benefit from combination prevention products in development such as microbicidal enemas that prevent HIV and STIs. TW who reported having a partner who uses PrEP were more likely to adhere to PrEP compared to those that do not engage with PrEP despite indication. This finding is consistent with existing literature demonstrating that social relationships and disclosure are associated with PrEP use; the role of dyadic and social network interventions warrant further exploration [31].

Those who were disengaged from healthcare were overrepresented in the consistent indication/no PrEP group. There is evidence that providing higher priority services (e.g., gender-affirming hormones, mental healthcare, and substance use treatment) can increase engagement in HIV prevention and care [11,21]. Anticipated discrimination in healthcare was prevalent overall (42.2%) but lower (though not statistically significant) in the PrEP initiation group (27.7%). Access to gender-affirming healthcare services that respect the needs and lived experiences of TW is critical for PrEP intervention success. This measure of anticipated healthcare discrimination is part of an intersectional discrimination scale which includes other forms of discrimination beyond transphobia (e.g., racism, sexism, and xenophobia). Thus, while gender-affirming services are a requisite for successful PrEP programming, these healthcare services and environments must also be inclusive and affirming of the other intersectional identities among TW they serve, particularly Black and Latina TW.

Strengths of this analysis include the large prospective sample comprised exclusively of TW, the innovative application of GBMTM to operationalize prevention-effective adherence trajectories, and the diversity of the sample in terms of age, race, and ethnicity. However, the study had some limitations. All data (except STI diagnosis) were self-reported, and therefore, subject to social desirability bias. Some measures (e.g., anticipated healthcare discrimination and healthcare engagement) were only assessed at baseline. Additional research using biological endpoints for adherence and exploring the impact of time-varying measures of healthcare access on PrEP engagement is needed. In addition, the measures of association reported were correlations (relative risk ratios). The direction of the effect between sociodemographic, clinical, and structural characteristics and the prevention-effective adherence trajectories cannot be assumed. Further quantitative and qualitative research to test the direction of these effects, characterize causal pathways, and inform targeted interventions based on prevention-effective adherence trajectory is underway. Finally, this analysis includes data from participants who completed follow-up prior to March 2020 and those who contributed data after March 2020; it is possible that the COVID-19 pandemic resulted in changes in PrEP indication and adherence in this sample, as has been reported in other populations in the United States, however we did not find statistically significant differences in our sensitivity analysis after accounting for secular trends [32].

Our analysis identified the distribution of prevention-effective adherence trajectories over an 18-month period among TW in a large, diverse, multisite cohort in the United States. We identified sociodemographic, clinical, and structural correlates, which highlight the importance of linkage to PrEP at STI diagnosis, housing interventions to support PrEP engagement and adherence, and the potential of dyadic and social network interventions to increase PrEP use among TW.

Author contributions

ALW and SLR conceived of the LITE cohort, secured funding, and led the overall project. EEC designed the analysis plan, wrote all statistical analysis code, produced all tables and figures, and wrote the first draft. EEC, ALW and SLR had full access to all data in the study, have verified the underlying data, and accept responsibility to submit for publication. ALW, SLR, HTS, KNA, SWB, TCP, CB, and KHM provided substantive input on study design and aided in interpretation of findings. EEC, ALW, and SLR obtained ethics ap-

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provals. ALW, AR, CC, JSS, JSH, AER, AJW, SLR, and KHM led study implementation at each site. ALW, SLR, HTS, KNA, SWB, TCP, and CB reviewed and edited the manuscript. All authors were involved in design and conceptual development and reviewed and approved the final manuscript.

Data sharing

De-identified individual data, a data dictionary, and code will be made available upon reasonable request after approval of a proposal and signing of a data use agreement. There is a formal process for external users to request access to LITE data, which involves review and approval by Principal Investigators from each study site as well as the Community Advisory Board; further details and forms can be obtained by emailing Dr. Andrea Wirtz (awirtz1@jhu.edu).

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.annepidem.2022.03.016.

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Exploring the Interpretation of Medical Students of the Brief Sexual Attitudes Scale

Bryana Williams, Elizabeth Duda, Keziah Daniels, and Jason S. Schneider

School of Medicine, Emory University, Atlanta, GA, USA

ABSTRACT

Effectively addressing the sexual health concerns of patients is critical to supporting and improving overall health for individuals and communities. This study aimed to collect validity evidence for use of the Brief Sexual Attitudes Scale (BSAS) in a sexual health curriculum among undergraduate medical students. A qualitative thematic analysis was conducted with three focus groups of medical students. Early findings indicate the need to modify the current version of the instrument to make it more useful to learners. A modified BSAS survey could help students understand their own perspectives about sexuality and how their perspectives influence their ability to provide non-judgmental patient care.

KEYWORDS

BSAS; medical student; curriculum; sexuality

Introduction

Sexuality is an integral part of health and wellness. It is incumbent on physicians to promote sexual health among other health promotion topics (Solursh et al., 2003). From the diagnostic and treatment perspective, sexual dysfunction is quite prevalent (Rosen, 2000). Sexually transmitted infections, such as the HIV epidemic, remain a critical issue for populations in the United States and globally (Prevention CfDCa, 2021). However, physicians are often reluctant to discuss issues related to sexuality and sexual health with their patients (Maurice & Bowman, 1999; O'Keefe & Tesar, 1999). This communication barrier renders invisible health issues considered important by patients and that prove relevant to public health. Douglas and Fenton note that a "more holistic and health-focused approach [to sexual health] … can positively affect public health problems related to sexual behavior (Douglas & Fenton, 2013).

When considering a curriculum for an individual educational program, it remains unclear what the optimal instructional methods are for undergraduate medical learners (Stayton, 1998; Thomas et al., 1980). Maurice

CONTACT Jason S. Schneider jsschne@emory.edu School of Medicine, Emory University, Atlanta, GA, USA.

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reported that a learner's proficiency in taking a sexual history from patients was related to their sexual experience (Rosen, 2000). After educating learners, those students who believed a sexual history was relevant to the medical interview improved their sexual history-taking skills. Thus, it is arguable that a medical student's experiences, beliefs, or attitudes toward sexuality may influence learning and adoption of patient-centered skills.

There is a need for evidence-based evaluation of sexuality curricula in medical education (Rubin et al., 2018; Solursh et al., 2003; Tucker et al., 2010). The sex knowledge and attitude test (SKAT) was developed, initially created in 1967, was developed to assess respondents' sexual knowledge, attitudes, and experiences (Miller & Lief, 1979). Miller and Lief created this scale in 1967 to measure participant attitudes in relation to four main categories: heterosexuality, sexual myths, masturbation, and abortion. A modified version of the scale, SKAT-A, was then developed to specifically assess how adolescent attitudes in these categories changed, if at all, after a sexual education curriculum was implemented. These actions emphasize the need for an appropriate tool to understand the impact of a sexual education curricula in a population, as well as the need for that assessment tool to be applicable to the population in question. In their original forms these instruments are not reflective of the breadth of gender and sexual diversity recognized in modern societies.

Although, the SKAT/SKAT-A importantly highlights the need for tailoring a measurement tool toward the population being assessed, as an older tool widely used among medical students to inform their sexual health curriculum, the tool also highlights the decrease in the utility of a tool utility over time. Researchers have found that although the SKAT was beneficial in assessing medical student attitudes before and after the introduction of a sexual health curriculum, in an attempt to use a validated tool as is, specific objectives and understanding of new knowledge introduced following the creation of the tool could prove to be a limitation in the tool's utility (Weerakoon & Stiernborg, 1996). Thus, a tool inclusive of the aims of the curricula, informed by the current knowledge within the realm of sex, sexuality and sexual health, is critical

The Brief Sexual Attitudes Scale (BSAS) is a 23-item instrument made up of four subscales: Permissiveness, Birth Control, Communion, and Instrumentality. Items are rated on a five-point Likert scale, ranging from strongly agree and strongly disagree. The Sexual Attitudes Scale (SAS) was developed in the late 1980s by Hendrick and Hendrick with the aim to assess multidimensional attitudes toward sex based on gender identity (Bailey et al., 1987). This husband-and-wife couple used the SAS to identify how gender orientation influenced an individual's attitudes toward their view of sex which they defined as one's "sexuality." The scale included 43

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items that aimed to understand individual views about 4 subcategories of sexuality: casual sex (permissiveness), sex as normal human bodily function (instrumentality), sex as a means of deeper love (communion), lastly, views on sexual practices and sexual education (birth control) (Bailey et al., 1987). After the scale's original development, it was found to have utility in assessing population attitudes toward sexuality and influenced policies surrounding sexual health including the effectiveness of contraception methods. Later, an abbreviated form of the scale, BSAS, was developed to test the same parameters in a briefer and more efficient way (Hendrick et al., 2006). The shorter version, BSAS, is what is more widely used today as a means of assessing sexual attitudes.

The BSAS was initially validated in 2006 utilizing studies of undergraduate college students as well as in two cohorts of psychology students (Hendrick et al., 2006; Kimberly et al., 2014). The authors utilized data from studies of the older, 43-item Sexual Attitudes Scale and prospective survey data ascertained with their modified version with the intent of demonstrating comparable psychometric performance. Previous research studies utilizing of the Sexual Attitudes Scale (SAS) compared the sexual attitudes of different populations, considering both gender and nationalities (Rubin et al., 2018). While validity evidence has been collected to determine how well the BSAS measures undergraduate students' sexual attitudes, similar validity evidence has not yet been collected in medical students.

Besides BSAS and SKAT/SKAT-A, other more modern surveys have been used to evaluate sexual attitudes in medical students. One such example is, the Sexual Health Education for Professionals Scale (SHEPS) has previously been used to evaluate the impact of a sexuality curriculum on medical student learners (Ross et al., 2018). SHEPS was created to specifically assess student healthcare trainee's confidence in their ability to address sexual health in patients. The study emphasized the need not only for a sexual health curriculum but the need for a useful tool to measure its effectiveness in strengthening trainee sexual health management abilities. Of the various types of medical trainees, medical students represent an important population of learners who may have different and varying attitudes toward sexuality (Leiblum et al., 1993; Ross, 2018; Shindel & Parish, 2013). These attitudes in turn can affect how they counsel patients about their sexual health even when they possess the necessary and fundamental biological and clinical knowledge (Leiblum et al., 1993). Thus, an instrument that measures changes in student sexual attitudes throughout the course of intervention proves beneficial to student readiness to provide apt sexual healthcare.

Given BSAS's use in the past to understand sexual attitudes, this tool provides a foundation toward understanding the best method of analyzing

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student sexual attitudes. A review of the literature demonstrates no previous investigation of the utility and appropriateness of the BSAS as an assessment tool for an undergraduate medical student population specifically. The purpose of this study is to, therefore, obtain initial, exploratory evidence to examine the utility of the BSAS and effectiveness of its application among undergraduate medical students.

Materials and methods

Study design

This is a qualitative, focus-group based investigation approved by the Emory University Institutional Review Board (IRB00111835). The study took place at Emory University School of Medicine with 1st year medical student participants. Focus group participants were recruited through E-mails to medical student class listservs. To maintain confidentiality and privacy, participants signed a consent waiver. Participants were not compensated monetarily for their participation, nor was participation linked to academic advancement. The study involved three focus groups occurring between June and August of 2019 with concurrent analysis between June 2019 and May 2020. The focus groups were conducted near the end of the academic year after students experienced two half-day learning sessions covering human sexuality and sexual health.

Data production

Three hour-long focus groups were attended by five to nine participants each (total 22 participants). The number of overall participants represented approximately 15% of the 1st year class at our institution. Gender and age demographics were collected with participants. No identifying information was collected, and names were de-identified in focus group transcripts. During each 60-minute focus group, a near-peer medical student member of the research team served as facilitator (i.e., 3rd year or 4th year medical student) using a "think aloud" technique to explore participants' understanding of selected items in the BSAS. The principal investigator, a member of the medical school faculty, was present at the session to take written notes. Participants were given a handout of the BSAS survey that included section headings and the 23 statements of the survey. Facilitators asked participants to share their understanding of these selected survey statements, thought by the authors to be representative of the overall instrument:

1. "I do not need to be committed to a person to have sex with him/her."
2. "One-night stands are sometimes very enjoyable."

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3. "Sex as a simple exchange of favors is okay if both people agree to it."
4. "Birth control is part of responsible sexuality."
5. "A sexual encounter between two people deeply in love is the ultimate human interaction."
6. "The main purpose of sex is to enjoy oneself."

The sessions were audio recorded to allow transcription and later analysis. Audio recordings were saved on the investigator's smartphone device, which was encrypted, and password protected. Transcription was completed immediately following the group sessions by a third-party provider.

Data analysis

Three of the authors (BW, ED, JSS), the faculty principal investigator and the two near-peer student facilitators, utilized inductive coding to describe underlying concepts that participants brought up in the focus groups (MacQueen et al., 2008; Namey et al., 2008). Initially, each member of the research team read the transcripts in their entirety, independently noting themes arising from the discussions in the focus groups. Next, the investigators met as a group to discuss findings, ultimately constructing a list of draft codes. The authors then utilized MAXQDA 2020 software to code the focus group transcripts (VERBI Software, 2019). The authors conducted their analysis independently. During the first cycle of coding, structural coding (Saldana, 2009) was used to create conceptual representations of topics generated during the three focus groups. The second cycle of coding used a combination of axial coding (Saldana, 2009), where emergent themes were linked together, and theoretical coding (Saldana, 2009) where more narrow codes were related to broader categories.

After concluding individual work, the three participating authors met and resolved any coding disagreements by consensus and verified the applicability of the coding structure. This also allowed the investigators to conclude they had reached saturation where no additional codes were emerging. By the end of the data analysis process, the researchers agreed upon the following ten codes: Outdated Language, Missing Topics, Lack of Inclusion, Distracting Terminology, Methodological Concerns, Ambiguity, Relative Perspective, Challenges with Grammar, Influence of Personal Experience, and Implied Judgment. These codes were clustered into four themes: (1) Significant Change in Attitudes (2) Lack of Clarity (3) Assessment of Societal Norms versus Personal Practices (4) Survey Structure.

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Results

Significant change in attitudes

This theme encompasses three codes: outdated language, missing topics and lack of inclusion. The participants described that the current language and perspectives around sexuality are quite different from when the survey was originally written. Medical students believe that attitudes have changed so drastically that the survey assesses outdated or irrelevant topics that are not consistent with how students currently understand sexuality. One person described the survey statements as reading "*Like [an] old school Lifetime movie, yeah. Very conservative, yeah. Not matching the times whatsoever.*" Another person stated, "*it just reads so dated … We need like a more updated [survey] that reflects like the culture that we live in today.*"

Participants noted that the sexual activities listed on the survey such as sex outside of marriage and "one-night stands" are more normative/mainstream in society today.

Participants expressed frustration that the BSAS survey developed in 1987, does not reflect attitudes and perspectives around diverse sexual activities and identities (i.e., bondage, discipline submission and masochism (BDSM), homosexual activity, polyamory, gender-non-binary, etc.). A separate participant noted, "*it's very centered on a relationship between a man and a woman … It's very nuclear family.*" Regarding the phrase, "Sex … is ok if both people agree to it," someone noted "*[it] narrows down to two and that's not necessarily how people engage in sex.*" Participants also objected to the use of "him/her" to describe a partner, noting a need for a "*gender-neutral premise*."

Generally, participants expressed a desire for the survey to reflect a broader range of sexual experiences. For example, in response to the statement "Birth control is part of responsible sexuality," an additional participant responded, "*we are not taking into account sexual experiences between people that wouldn't get pregnant at all.*"

In addition to noting the outdated and limited scope of the language utilized in the survey, medical students identified missing or truncated topics that they value and deem worthy of further assessment. One person said, "*I think … a sexual attitudes survey would benefit from a STI centered question versus birth control*" and someone else said "*Birth control" is not implying safe sex from … STIs.*" Regarding discussions of birth control, one person noted "*Most people, at least women, might think of birth control as in hormonal birth control or IUD. I think it's more associated with those types of things, whereas other forms of contraceptives could also be used for birth control.*" Participants also felt that the survey would benefit from language that incorporated modern concepts of consent.

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Lack of clarity

This theme encompasses two codes: distracting terminology and ambiguity. Overwhelmingly, medical students wanted more clear and specific instructions as to how they should answer questions. There was a consensus that explicit definitions of words like "sex," "birth control" would be helpful for medical students to accurately interpret what is being asked in the statements. The ambiguity of statements and terms led to significant confusion for participants such that disengagement from active completion of the survey was a risk.

For some people, items were perceived as very straightforward, while others found the statements unclear. One example being the phrase, "the merging of two souls," a phrase found in one of the items not highlighted by the investigators. It was more uniformly understood by participants in contrast with "simple exchange of favors" that was a point of general contention and debate in several focus groups.

Several participants described a lack of synchronicity in terms of what each word meant alone or combined with others in the statement. Participants brought up the idea that each word added to a statement has the possibility to clarify or confuse a sentence. Examples of a more straightforward statement would be "the main purpose of sex is to create offspring" that participants could agree to on a Likert scale. This particular cohort of medical students demonstrated a tendency to deeply contemplate the meaning behind questions in an effort to "get the right answer:"

> Because whenever you're trying to interpret what the writer is saying or trying to … it becomes like you're trying to play a game and you're trying to, generally … most of us are conditioned to be like, "I wanna get a 100% on this test." So, you're trying to answer it correctly.

Societal norms versus personal practices

This theme includes three codes: relative perspective, influence of personal experience and implied judgment. The students describe confusion around which perspective of belief is asked in the statement, the perspective of self versus general society. Participants questioned if they should be answering the statements based on their actual behaviors or based on ideal behaviors that people in general should practice.

> You could clarify, is it about asking … the person that you're talking to … or is their perspective towards it for the general population, but not necessarily about themselves? And I think you can rewrite the question to make that clearer.

The participants also mentioned the point that that being clear about answering the statements from a personal perspective or societal norm

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perspective would have broader implications. Not only would clarifying the perspective of the question make it easier for students to answer the question, but clarity would also make it easier for researchers to interpret the responses.

> Speaker 2: "How would you analyze data that people answered via different interpretations, that's not going to reflect their different attitude of text. That's going to just reflect how they interpreted differently, these questions? I don't think that's the purpose of this study."
>
> Speaker 4: "But there are, I guess … Would there be multiple people that interpret the same way? Even if it's for one question, three or four different interpretations. But there might be several people that thought … X, so they chose that. People thought … Y so they chose this."

The participants also brought up that terminology used on the BSAS survey, such as "one-night stand" may have different meanings and connotations to various respondents.

> Speaker 1: "This also seems to imply that the person that you're asking has had a one -night stand and would be able to comment on it, when that's not necessarily true either."
>
> Speaker 3: "Oh yeah, there should be like, in the Likert scale, just-"
>
> Speaker 2: "Does not apply … "
>
> Speaker 3: "Yeah, does not apply."

The phrase "loaded" statements was used multiple times by participants that conveyed a kind of implied judgment. Participants described strong feelings that many statements presented a "loaded question" with moral value attached to it. Phrases such as "responsible sexuality" were interpreted as being ambiguous or loaded with an implied value that many participants found difficult to interpret.

> I think if you read that statement, you would assume this was being written from like a heteronormative Judeo-Christian world view and I think if you were a person who didn't ascribe to those values, you might read the rest of the survey in a way that was judgmental. And I don't think that's what you're trying to get at in the survey.

Participants also disliked statements that read as all-or-nothing, such as "Birth control is part of responsible sexuality." The medical students preferred answering questions that are written as "can be" rather than "always are." They also expressed concern about judging other people's sexual practices. They described that the survey as written suggests that people who don't use birth control are having irresponsible sex. In general, participants felt there was inconsistency in the survey statements between implied judgment of statements. The participants suggested statements be worded as a sexual activity "could be" something (enjoyable) rather than "should be" something (enjoyable).

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Survey structure

Finally, this theme is composed of two codes: methodological concerns and challenges with grammar. Students described a desire for clearer instructions and open-ended questions. Medical students brought up several issues with the utility of having the survey at all. Some participants suggested having a "not applicable" option if a person has never experienced (one-night stand, any sexual activity).

> I just feel like it's such a complex topic that narrowing it down to a scale in terms of just wanting us to talk about these questions was difficult… I feel like this is always going to be a problem in medicine. Having a quantitative scale is very easy and very good for research purposes, but qualitative interviews can kind of elucidate some of these nuances a bit more, but also how do you implement results from a qualitative study into clinical practice? So, I think just from a meta point of view, it's hard to use a scale like this with such a nuanced topic that is always going to be changing in the future as well.

Many participants felt that the organization of the questions on the BSAS survey was problematic. Several students suggested changing the order of questions so that all statements surrounding a certain topic, such as birth control, were not all grouped together. Participants also brought up the idea of re-wording the questions so that they could be randomized on the survey.

> So, I think that comes to a bigger problem, is that these questions would need to be written in a way that they can be interpreted without the context clues of other questions. And I think that some of these questions are not written in a way that they can stand alone.

Participants described it as being easier to consider smaller, specific statements than broad statements that consider multiple concepts. Students described that the order of words or use of multiple concepts within a statement was confusing; a person could agree with part of a statement and disagree with another part.

> I figure it would make it easier to read or more straightforward if they were all written in the same way. So, like, sex is a pleasurable act, sex is meant for reproduction, sex is only between two people. Because then you can really kind of rapid fire, go through it quickly, and just agree or disagree with the statement. [The statement] "I do not need to be committed to a person to have sex with him/her." You're like, "Hmm." You have to really think about it.

Discussion

The genesis of this project was a need to evaluate the impact of a human sexuality curriculum for undergraduate medical students. The principal investigator was familiar with the Brief Sexual Attitudes Survey, and initially planned to utilize this instrument to assess the curriculum. However, the literature review demonstrated that the BSAS had not previously been utilized in our population of interest. Thus, our research team embarked

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on this effort to investigate the utility of the survey among medical students in assessing their own attitudes toward sexual behavior, sexuality, and sexual orientation. The results emphasize the critical point that various aspects of this tool make it ineffective at assessing the attitudes for these parameters specifically in a medical student population.

In order to elicit an inclusive sexual history in a non-judgmental manner, learners must confront their own discomfort and attitudes about the topic of sexuality. An ideal curriculum would allow learners to explore the ways their internal beliefs influence outward biases toward patients, thereby affecting their medical practice (Papaharitou et al., 2008; Schulte & Kay, 1994). As part of the proposed competencies for sexual health education in North America, Bayer et al recommend that learners consider implicit bias associated with sexual health topics as part of patient care. An instrument that assesses attitudes of learners in an objective way would address this competency (Bayer et al., 2017). Medical education literature shows there is a need to create evidence-based evaluation tools for sexuality education curricula (Shindel & Parish, 2013; Tucker et al., 2010; Wiggers et al., 1977). A effectively designed curriculum would directly impact the attitudes of learners regarding the topic of human sexuality and behavior. An ideal evaluation tool would assess learners' attitudes about other's sexual practices that can influence patient care.

The BSAS was designed to assess personal beliefs about the respondents' current sexual practices. The introductory paragraph for the BSAS asks respondents to answer based on their subjective individual experiences. Data gathered from our focus groups suggests that the survey indirectly assesses a respondent's attitudes about societal norms. Embedded within the items on the BSAS are value statements about what is seen as normal and abnormal sexual behavior. For the purposes of medical education, understanding attitudes about societal norms is more relevant to future health care professionals.

An optimal instrument would be useful in evaluating medical student beliefs for two main reasons. First, using the BSAS provides a wealth of history in how the survey has been used in different populations. This history is useful in comparing previous findings to current research. Second, creating a new survey from scratch would be very time-consuming and labor-intensive.

We recommend several modifications to the instrument for it to be used as an assessment tool for undergraduate medical curricula.

A modified instrument for educational purposes should include:

1. Expanding the behavior assessed in the survey to include consent for sexual activity, sexually transmitted infections (STI), and same-sex or

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same-gender sexual activity.

A major problem with using the BSAS with present day medical students is the narrow scope of sexual activities that are currently assessed on the survey (Kimberly et al., 2014). Yes, it is practically impossible for a single survey to be fully inclusive of the diversity of human sexual experience and increasing the domains and types of sexual practices assessed would make the survey unwieldy. However, the survey explicitly and implicitly inquires only about heterosexual activity, and this is an inherent deficiency of the BSAS. Increasingly, research has indicated the drastic need to increase undergraduate medical education for care of lesbian, gay, bisexual, and transgender/gender-fluid patients is documented by focus group participants as well as in other literature (Obedin-Maliver et al., 2011). Recommendations for survey revision include using gender inclusive pronouns, constructing item language to be inclusive of multiple partners (e.g., "for all parties involved"), and explicitly addressing STIs and pregnancy.

2. Use of inclusive and non-judgmental language.

   An ideal survey would provide specific statements of sexual activities without alienating many participants (Rickards et al., 2012). Controversial or extreme statements can be useful in the survey as they accommodate discrimination in respondent attitudes. Neutral statements run the risk of having most participants answer in the middle of a Likert scale range. Optimally, items can be revised to evaluate attitudes about sexuality (e.g., "Sex should only be for procreation" or "Sex without emotional attachment") without implied judgment.

> If you keep this on the survey, this would alienate people, but you will get some people and, I don't know, that's useful in and of itself. To see what kind of people you end up … that respond very highly … or that respond very positively this kind of … section.

3. A glossary of terms used in the instrument to avoid respondents utilizing their own interpretations.
4. Additionally, a sizable portion of the discussion captured in the focus groups reflected unclear instructions for the instrument. Notably, not all participants were confused by the same items. This suggests a lack of clarity of the questions and its influence on the utility of the survey as an effective analytical tool.

> Just some general feedback to you, I think I would define sex at the top when you're reading it because just right at the bat, people can interpret sex a lot of different ways. Intercourse, oral sex, anal sex, do you want to include all of these in this survey or just a specific type of sex? So, I think just defining that at the beginning might be useful as well.

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5. A limited word count for survey items to avoid respondent confusion. Participants can overthink lengthy statements with multiple embedded phrases or concepts. The instrument can be made easier to read by shortening the items to avoid distracting words.

Limitations

Significant selection bias in this study comes from the demographics of the medical students who volunteered to participate in the focus groups. Many students tended to be more progressive in their views on sexuality; thus, we may be missing a wider range of perspectives in our study.

Participants had a lot of discussion about the section headings that described certain constructs in the survey such as "permissiveness" and "communion." While discussions about these headings in the survey were useful to inspire dialogue among the participants, these headings led to diverging conversations. Since these section headers are not usually visible to people taking the survey, in future research using the BSAS survey we would suggest omitting these section headers from the survey given to participants.

The faculty principal investigator was present during the small group sessions, and this may have influenced medical student participant responses with an assumption that answers should adhere to a norm based on the faculty member's work in sexual health and sexual health education. Students were regularly encouraged to be honest and give their personal views whether or not they themselves thought they were contrary. Having a near peer student serve as facilitator also mitigated the bias of the presence of the faculty investigator.

Conclusion

Past studies have determined that providers' personal perspectives about sexuality can influence their ability to provide impartial care. These personal views can negatively affect patient care and population health. Additionally, past studies indicate that a potential solution to this problem is a curriculum that educates undergraduate medical students about sexual health concerns reflective of their current patient population. Thus, a tool to accurately measure and describe changes in student attitudes toward sexuality is necessary. Our study has shown that an approach beyond BSAS, even in a modified form, is needed to effectively analyze how student perspectives about sexuality is influenced by the implementation of a sexual education curriculum.

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Future directions

1. Addressing determined limitations of BSAS
   A proposed next step includes utilizing individual interviews of the respondents in this study to further explore their understanding and interpretation of items on a modified BSAS. Individual or small group interviews can be done to assess the clarity, objectiveness, and representation of modern-day sexual health concerns/treatments of an updated instrument compared to the BSAS. Our study has found that one of the innate limitations of the BSAS is both the time period that it was created and validated as a tool for assessing sexual attitudes and, in alignment with that, also the specific population that it was created for. Tools such as SKAT/SKAT-A have highlighted the need to tailor a tool toward the population of interest and not the other way round. Our study has also highlighted that even when assessment tools are created for a specific population, the validity of that tool must be assessed over time because the population itself is dynamic. Thus, we must take great consideration of the necessary aspects of sexual health relevant to undergraduate medical students *now* as well as determining the general composition of this population at this time. Continuing this iterative process will allow comprehensive validation of the BSAS among medical students and can inform subsequent modifications of the survey.
2. Modification of the BSAS with the aid of modern assessment tool(s).
   Our study primarily revealed the deficiencies in using BSAS to assess medical student attitudes toward sexual health. Another proposed next step includes investigating more modern surveys and determining how these address limitations of BSAS. The SHEPS tool was developed in the 2010s compared to BSAS with its origin in the 1980s. SHEPS is more focused on the knowledge that health care providers have about sexuality while the BSAS is more targeted to the general population (Miller & Lief, 1979). Furthermore, the SHEPS tool may be better than the BSAS at measuring the sexual attitudes of medical students given that this survey consists of distinct questions that assess sexual health communication skills, knowledge and attitudes around sexual health (Rubin et al., 2018). Thus, the SHEPS tool offers a prime comparison to what a modified version of the BSAS could be and more studies should be done to further investigate in what ways SHEPS addresses the limitations of BSAS.

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ORCID

Elizabeth Duda http://orcid.org/0000-0001-8717-8167
Keziah Daniels http://orcid.org/0000-0002-0166-0057
Jason S. Schneider http://orcid.org/0000-0002-6265-0370

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Perceived HIV Acquisition Risk and Low Uptake of PrEP Among a Cohort of Transgender Women With PrEP Indication in the Eastern and Southern United States

Jowanna Malone, MSc,[a] Sari L. Reisner, ScD,[b,c,d] Erin E. Cooney, MSPH,[e] Tonia Poteat, PhD, PAC, MPH,[f] Christopher M. Cannon, MPH,[g] Jason S. Schneider, MD, FACP,[h] Asa Radix, MD, PhD, MPH, FACP,[i] Kenneth H. Mayer, MD,[j,k] J. Sonya Haw, MD,[l] Keri N. Althoff, PhD, MPH,[a] Andrew J. Wawrzyniak, PhD,[m] Chris Beyrer, MD, MPH,[n] and Andrea L. Wirtz, PhD,[a]

For the American Cohort to Study HIV Acquisition Among Transgender Women (LITE) Study Group

Introduction: Preexposure prophylaxis (PrEP) is effective in preventing HIV among adherent users. However, PrEP uptake among transgender women is low, and current prescribing guidelines from the Centers for Disease Control and Prevention (CDC) are not specific to transgender women. Self-perceived risk of HIV among those who are PrEP-indicated is not well understood.

Methods: This cross-sectional analysis included 1293 transgender women screened at baseline from March 2018 to May 2020 for a multisite, prospective cohort study. We compared the prevalence of PrEP indication using current CDC prescribing criteria versus transgender women–specific criteria developed by study investigators with community input. We identified factors associated with study-specific PrEP indication and factors associated with self-perceived low to no HIV risk among those who were PrEP-indicated. We also calculated descriptive statistics to depict the PrEP care continuum.

Results: PrEP indication prevalence using transgender women–specific criteria was 47% (611), 155 more than who were identified using the CDC criteria. Eighty-three percent were aware of PrEP, among whom 38% had ever used PrEP. Among PrEP ever users, 63% were using PrEP at the time of the study. There were 66% of current PrEP users who reported 100% adherence within the previous 7 days. Among those who were PrEP-indicated, 13% were using and adherent to PrEP at the time of the study. More than half (55%) of PrEP-indicated participants had low or no self-perceived HIV risk.

Conclusions: These findings suggest that further guidance is needed for health care providers in prescribing PrEP to transgender women. Greater uptake and adherence are also needed for optimal effectiveness.

Key Words: transgender women, PrEP indication, health belief model, self-perceived risk, HIV prevention

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INTRODUCTION

Transgender women experience a disproportionate burden of HIV, with an estimated prevalence of approximately 14%–28%.[1,2] Preexposure prophylaxis (PrEP) has been established as a highly efficacious means for preventing HIV acquisition,[3–5] even in the presence of hormone

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From the [a]Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD; [b]Department of Epidemiology, Harvard T.H. Chan School of Public Health, Boston, MA; [c]Department of Medicine, Harvard Medical School, Boston, MA; [d]Division of Endocrinology, Diabetes & Hypertension, Brigham and Women's Hospital, Boston, MA; [e]Department of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD; [f]Department of Social Medicine, University of North Carolina Chapel Hill School of Medicine, Chapel Hill, NC; [g]Research, Whitman-Walker Institute, Washington, DC; [h]School of Medicine, Emory University, Atlanta, GA; [i]School of Medicine, New York University, New York, NY; [j]Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, MA; [k]Fenway Community Health Center, The Fenway Institute, Boston, MA; [l]Division of Endocrinology, Metabolism, and Lipids, School of Medicine, Emory University, Atlanta, GA; [m]University of Miami Miller School of Medicine, Miami, FL and [n]Department of Epidemiology, Center for Public Health and Human Rights, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD.

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Correspondence to: Jowanna Malone, MSc, Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health, 615 N. Wolfe Street, W6030, Baltimore, MD 21205 (e-mail: jmalone23@jhmi.edu).

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therapy.[6] However, there is still a dearth of evidence concerning the effectiveness of PrEP among transgender women. Although there is research that has explored facilitators and barriers to oral, daily PrEP usage and acceptability of PrEP among transgender women, much of this research has grouped this population with cisgender men who have sex with men (MSM).[7,8] In addition, this work has not explored the role of self-perceived HIV acquisition risk in the context of PrEP use. Thus, there is a need to focus on PrEP implementation efforts among transgender women and identify means to improve PrEP uptake.

Given the high burden of HIV among transgender women, PrEP uptake is likely to have high effect in reducing acquisition for those who are sexually active (or PrEP-indicated).[9] The social marginalization and oppression experienced by transgender women have simultaneously led to increased risk of HIV acquisition (compared with the general population) and decreased access to HIV prevention services.[10] Social exclusion (eg, exclusion from formal employment and education) and unmet need for gender affirmation are associated with increased behavioral risk factors of HIV acquisition such as engagement in sex work and condomless receptive anal sex.[11] Adverse childhood events, which are more prevalent among transgender people than cisgender people,[12] have also been associated with high HIV acquisition risks.[13] However, uptake of oral, daily PrEP remains low among transgender women.[11] Furthermore, current PrEP indication guidelines from the Centers for Disease Control and Prevention (CDC) are not specific to transgender women because they only explicitly provide criteria for cisgender MSM, heterosexually active cisgender men and women, and people who inject drugs.[14] Although the guidelines acknowledge that transgender people could potentially benefit from PrEP,[14] no guidelines have been developed specifically for transgender women despite being one of the most affected populations in the US HIV epidemic. In practice, the CDC PrEP prescribing criteria for MSM are often applied to transgender women.

Along with the need for PrEP prescribing criteria that are specific to transgender women, it is also important to ensure that those who are indicated for PrEP are aware of their risk of HIV acquisition. Behavioral models, such as the Health Belief Model, posit that a person's perceived risk of adverse health is important in determining whether they will adopt a given health intervention.[15] Such models suggest that an individual's self-perceived threat for a given disease, along with their perception of the level of efficacy of a health intervention for that disease, will dictate whether they will adopt a given health behavior.[15] Thus, it is possible that transgender women who are behaviorally indicated for PrEP use, but who do not perceive themselves as being at risk of HIV acquisition, may be less likely to inquire about or start using PrEP. Research is needed to evaluate perceived risk of HIV acquisition among transgender women in relation with PrEP indication.

This analysis evaluated the use of PrEP prescribing criteria that are specific to the HIV acquisition risks of transgender women and the self-perceived risk of HIV among these women. We also reported levels of engagement throughout the PrEP care continuum. These analyses aimed to identify gaps in PrEP engagement among transgender women and potential opportunities where PrEP messaging may be improved for this population.

METHODS

Study Design and Setting

The American Cohort to Study HIV Acquisition Among Transgender Women (known to participants as the LITE study) is a multisite, observational cohort study enrolling HIV-negative transgender women (N = 1293 as of May 2020) across the southern and eastern United States. The cohort includes 2 arms: a site-based cohort (N = 747) in 6 eastern and southern US cities (Atlanta, Baltimore, Boston, Miami, New York City, and Washington, DC) and an online cohort (N = 546) in more than 50 metropolitan areas throughout the eastern and southern United States. The purpose of the study is to follow-up participants over a two-year period to estimate HIV incidence and describe the factors associated with HIV acquisition. Participants complete sociobehavioral surveys and biological testing for HIV, on a quarterly basis for site-based participants and every 6 months for online cohort participants. Participants in the site-based cohort also receive annual sexual transmitted infection (STI) testing (syphilis, gonorrhea, and chlamydia) and biospecimen collection. Survey topics for both online and site-based cohorts span domains of sociodemographic characteristics, gender affirmation and pride, general health, sexual health and behaviors, mental health and substance use, and social experiences including violence, discrimination, and social support. Study design and implementation were informed by ongoing discussions with a Community Advisory Board, with membership spanning the cohort's geographic region and through formative research.[16,17] Methods associated with the site-based cohorts are previously described in the published protocol.[18] This study is a secondary analysis using cross-sectional data from baseline study visits completed between March 2018 and May 2020. All study procedures were reviewed and approved by the Johns Hopkins School of Medicine institutional review board (IRB) for all study sites.

Participant Selection

Participants were recruited through online advertisements on social media and dating apps (both cohorts) and through traditional convenience sampling methods including peer referral, fliers, and referrals from clinics and community-based organizations (site-based cohorts only). Eligibility criteria included being 18 years or older; endorsing a transfeminine identity based on a two-step measure of being assigned male sex at birth and identifying as female sex, gender nonconforming, nonbinary, or being on the transfeminine spectrum; residing in one of the 6 site-based cities (site-based cohort) or one of the 50 eastern and southern cities (online cohort); testing negative for antibodies to HIV on screening using oral specimen testing (online cohort) or the OraSure HIV self-test (site-based cohort); speaking English

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and/or Spanish language; and providing consent to participate in at least the baseline study visit.

Outcomes of Interest

PrEP Indication Definition

This article compares the CDC's definition of PrEP indication used for MSM, which is often applied to transgender women, with a definition developed by the LITE study investigators with community input and based on HIV risk factors that are more specific to transgender women. The current CDC PrEP prescribing criteria include having any cisgender male sex partners in the past 6 months, not being in a monogamous sexual partnership with a known HIV-negative cisgender man, and at least one of the following: any anal sex act without a condom in the past 6 months or having an STI within the past 6 months (Table 1).[14] Given the frequency of follow-up and recall periods in the LITE study, laboratory-confirmed or self-reported STI diagnosis in the past 3 months and condomless sex act during the last sexual encounter were used as proxies for these CDC indicators. PrEP indication criteria suggested by the LITE study investigators with community input (in addition to the CDC criteria) include the following: (1) recent sex work (within the past 3 months), (2) use of postexposure prophylaxis, (3) recent sex act with a partner living with HIV or of unknown HIV status (within the past 3 months), and (4) needle sharing when injecting drugs within the past 12 months. Participants reported "yes" or "no" for each of these criteria on the sociobehavioral survey.

TABLE 1. Comparing CDC and LITE Study PrEP Prescribing Criteria

PrEP Indication Criteria	
CDC (MSM Specific)	**Study-Specific Criteria for TGW (Italicized)**
Current negative HIV serostatus.	Current negative HIV serostatus.
Any cisgender male sex partner within the past 6 mo.	Any cisgender male sex partner within the past 6 mo.
Not in a monogamous sexual partnership with an HIV-negative cisgender male sex.	Not in a monogamous sexual partnership with an HIV-negative cisgender male sex.
In addition, at least one of the following:	And at least one of the following:
Anal sex without a condom within the past 6 mo	Anal sex act without a condom within the past 6 mo
Having an STI within the past 6 mo	Having an STI within the past 6 mo
	Report current sex work (within the past 3 mo)
	Reported use of postexposure prophylaxis
	Sex act with a partner living with HIV within the past 3 mo
	Sex act with a partner of unknown HIV status with in the past 3 mo
	Needle sharing of injection drugs within the past 12 mo

Self-Perceived Risk of HIV Acquisition

Perceived risk of HIV acquisition was measured by the question "How high do you think your risk of HIV infection is?", with answer choices of no risk, low, medium, or high risk. For this analysis, we dichotomized responses to combine "no" or "low" risk to a low-risk category vs. a high-risk category if they reported "medium" or "high" risk.

Variables of Interest

We examined age, race, education, employment, health insurance, income level, drug use, social support, homelessness, adverse childhood experiences (ACEs), and experiences of psychological violence for associations with PrEP indication. Age was dichotomized to compare participants older than 30 years with those younger than 30 years (the median age was 28 years; thus, we chose to consider those younger than 30 years as "young" participants). Low income was defined as living below the federal poverty line. Social support was measured through a modified version of the California Health Interview Survey Social Support Index in which participants answered 5 questions (eg, "How often have you had someone available to take care of you if you are sick?") and provided responses on a 5-point Likert scale ranging from 0 (none of the time) to 4 (all the time), with response totals ranging from 0 to 20. Response totals more than 10 were categorized as "high" social support (Cronbach alpha: 0.87).[19] We used the Drug Abuse Screening Test-10 tool[20] to screen for drug use disorder based on activity within the past 12 months. The Drug Abuse Screening Test-10 provides a score from 1 to 10, and scores of 3 or greater are classified as moderate to severe substance use disorder (Cronbach alpha: 0.72). We also used the CDC's Behavioral Risk Factor Surveillance System's ACE questionnaire, which measures instances of child abuse or neglect.[21] ACE scores ranged from 0 to 8, and the higher the score, the greater the number of reported adverse childhood events (Cronbach alpha: 0.64). Responses were dichotomized with those reporting 3 or fewer ACEs in the "low" ACE group and those reporting 4 or more in the "high" ACE group. Participants also reported whether they experienced any occurrence of psychological violence within the past 3 months. This was defined as any occurrence in which a participant had been insulted, belittled, intimidated, or threatened to disclose their gender identity to others without their consent.

PrEP Care Continuum

In the survey, participants reported whether they had heard of daily, oral PrEP, if they had ever taken PrEP, if they were currently using PrEP, and how adherent they were in their PrEP use. Self-reported PrEP use in the past 30 days before the survey was classified as current PrEP use. Adherence to daily, oral PrEP was defined as not missing a dose of PrEP medication within the past 7 days before the survey. This level of adherence is based on lack of evidence that any dosing less than 7 pills in 7 days is protective for individuals using exogenous hormones.[22]

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TABLE 2. Sociodemographics of TGW by PrEP Indication Status (N= 1293) (as of January 5, 2020)

	Total = 1293	PrEP Indication by CDC = 456	Transgender-Enhanced PrEP Indication* = 155	
Demographics	**N (%)**	**N (%)**	**N (%)**	***P***
Study site				0.99
Baltimore, MD	78 (6)	38 (8)	12 (8)	
Boston, MA	170 (13)	52 (11)	16 (10)	
New York City, NY	221 (17)	90 (20)	34 (22)	
Atlanta, GA	64 (5)	30 (7)	9 (6)	
Miami, FL	92 (7)	43 (9)	15 (10)	
Washington, DC	122 (9)	48 (11)	14 (9)	
Online	546 (42)	155 (34)	55 (36)	
Age, yrs				
Younger than 30	735 (57)	284 (62)	76 (49)	
30 or older	554 (43)	172 (38)	79 (51)	0.004
Race				
Non-Hispanic/Latinx White	676 (53)	184 (41)	58 (38)	
Non-Hispanic/Latinx Black	174 (14)	93 (21)	20 (13)	
Hispanic/Latinx (any race)	109 (9)	54 (12)	23 (15)	0.08
Other	317 (25)	120 (27)	52 (34)	
Education				
High school or less	360 (28)	164 (36)	56 (37)	0.96
Some college or more	921 (72)	290 (64)	98 (64)	
Employment				
No employment	517 (41)	190 (43)	63 (42)	
Employed (part-time)	279 (22)	105 (24)	40 (27)	
Employed (full-time)	457 (36)	151 (34)	47 (31)	0.71
Health insurance				
Yes	1036 (80)	350 (78)	116 (76)	0.65
No	243 (19)	101 (22)	37 (24)	
Low income				
Below poverty level	418 (38)	164 (42)	73 (52)	0.06
Above poverty level	675 (62)	224 (58)	69 (49)	
Drug abuse screening test-10				
Above moderate drug use	361 (28)	148 (33)	62 (41)	0.08
Below moderate drug use	917 (72)	303 (67)	91 (60)	
Social support				
Low social support score	568 (45)	197 (44)	81 (54)	0.04
High social support score	684 (55)	249 (56)	69 (46)	
Ever experienced homelessness				
Yes	557 (44)	238 (53)	81 (53)	0.93
No	720 (56)	215 (47)	72 (47)	
Adverse childhood experiences				
Low adverse childhood experiences	693 (55)	229 (51)	67 (45)	0.16
High adverse childhood experiences	571 (45)	217 (49)	83 (55)	
Recent threat of violence (within the past 3 mo)				
Yes	508 (47)	205 (55)	67 (44)	0.75
No	570 (53)	171 (45)	85 (56)	

*Enhanced PrEP Indication refers to participants who were considered to be indicated for PrEP based on study criteria but not based on CDC criteria.

Analysis

PrEP Indication

We compared the number of additional participants that would be indicated for PrEP when using the study-specific PrEP indication definition versus the CDC's definition. We then conducted bivariable and multivariable analyses to determine the factors associated with having indications for PrEP using our revised criteria for transgender women. We estimated adjusted prevalence ratios (aPR) using a multivariable Poisson regression model with robust variance, adjusting for race/ethnicity, education, health insurance, drug use, lifetime housing stability, ACEs score, experiences of psychological violence victimization within the past 3 months, and study site. To build the multivariable

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TABLE 3. Sociodemographics Associated With the LITE Study–Specific PrEP Indication in TGW (N = 1293)

Demographics	PR (95% CI)	*P*	aPR (95% CI)	*P**
Study site				
Baltimore, MD	Ref	—	Ref	—
Boston, MA	0.62 (0.49 to 0.80)	<0.001	**0.77 (0.60 to 1.00)**	**0.05**
New York City, NY	0.88 (0.71 to 1.07)	0.20	0.87 (0.71 to 1.06)	0.16
Atlanta, GA	0.95 (0.74 to 1.22)	0.70	1.02 0.79 to 1.33)	0.86
Miami, FL	0.98 (0.78 to 1.24)	0.89	0.90 (0.71 to 1.15)	0.39
Washington, DC	0.79 (0.62 to 1.01)	0.06	0.87 (0.69 to 1.11)	0.26
Online	0.60 (0.49 to 0.73)	<0.001	**0.78 (0.63 to 0.96)**	**0.02**
Race				
Non-Hispanic/Latinx White	Ref	—	Ref	—
Non-Hispanic/Latinx Black	1.81 (1.43 to 2.31)	<0.001	**1.53 (1.28 to 1.83)**	**<0.001**
Hispanic/Latinx	1.97 (1.61 to 2.41)	<0.001	**1.76 (1.47 to 2.11)**	**<0.001**
Other	1.52 (1.16 to 1.98)	0.002	**1.39 (1.19 to 1.62)**	**<0.001**
Education				
High school or less	Ref	—	Ref	—
Some college or more	0.69 (0.66 to 0.72)	<0.001	**0.82 (0.72 to 0.92)**	**0.001**
Health insurance				
No	Ref	—	Ref	—
Yes	0.79 (0.71 to 0.89)		0.96 (0.84 to 1.09)	0.52
Drug abuse screening test				
Below moderate drug use	Ref	—	Ref	—
Above moderate drug use	1.35 (1.14 to 1.61)	0.001	**1.34 (1.19 to 1.52)**	**<0.001**
Ever experienced homelessness				
No	Ref	—	Ref	—
Yes	1.44 (1.34 to 1.54)	<0.001	**1.15 (1.02 to 1.29)**	**0.025**
Adverse childhood experiences				
Low adverse childhood experiences	Ref	—	Ref	—
High adverse childhood experiences	1.23 (1.11 to 1.37)	<0.001	1.04 (0.93 to 1.18)	0.48
Recent occurrence of psychological violence (less than 3 mo)				
No	Ref	—	Ref	—
Yes	1.23 (1.06 to 1.43)	0.006	**1.19 (1.06 to 1.34)**	**0.003**

*All bolded entries represent adjusted estimates that were statistically significant at a 0.05 alpha level.

model, we conducted the Pearson χ^2 test for each variable and selected those that were statistically significant at 0.10 alpha level. We excluded poverty level and employment status because they were highly correlated with education.

Self-Perceived HIV Risk Among PrEP-Indicated Participants

Among those who were PrEP-indicated based on those criteria, we repeated the same model-building procedures to identify factors associated with reporting self-perceived low HIV risk. The variables for this model included age (ie, being younger than 30 years or aged 30 years or older), education level, substance use, social support, lifetime housing stability, and ACEs score. We also calculated descriptive statistics to characterize the PrEP care continuum and tabulated the percentage of participants who were aware of PrEP, had health insurance coverage, currently used PrEP, and were adherent to PrEP among those who were PrEP-indicated based on transgender-specific criteria. Study site and current PrEP use (within the past 30 days) were included in the model. All analyses were conducted using Stata 15 software.[23]

RESULTS

Descriptive Characteristics

As of May 2020, 1293 participants who showed a negative result for HIV test were enrolled in the baseline visit. Among them, 57% were younger than 30 years, 14% were identified as non-Hispanic/Latinx Black, 28% reported less than high school education, and 72% endorsed low perceived HIV acquisition risk (Table 2). Eleven percent of participants reported current PrEP use at the time of enrollment.

Differences in Level of PrEP Indication Based on Study Versus CDC Criteria

Of the 1293 participants, 456 (35%) participants (Table 2) were indicated for PrEP based on CDC criteria compared with 611 (47%) participants using the enhanced criteria for transgender women. Thus, an additional 155 participants were

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TABLE 4. Factors Associated With Self-Perceived Low Risk of HIV Acquisition Among PrEP-Indicated TGW (N = 504)

Demographics	PR (95% CI)	*P*	aPR (95% CI)	*P**
Study site				
Baltimore, MD	Ref	—	Ref	—
Boston, MA	1.05 (0.72 to 1.54)	0.79	1.01 (0.68 to 1.52)	0.95
New York City, NY	1.07 (0.77 to 1.50)	0.68	1.12 (0.79 to 1.59)	0.51
Atlanta, GA	1.17 (0.78 to 1.74)	0.45	1.05 (0.68 to 1.62)	0.82
Miami, FL	1.05 (0.72 to 1.55)	0.79	1.09 (0.73 to 1.63)	0.68
Washington, DC	1.06 (072 to 1.55)	0.78	1.00 (0.67 to 1.49)	0.996
Online	1.20 (0.87 to 1.65)	0.27	1.09 (0.78 to 1.53)	0.60
Age, yrs				
30 or older	Ref	—	Ref	—
Younger than 30	1.21 (1.05 to 1.39)	0.007	**1.26** (**1.04** to **1.53**)	**0.02**
Education				
High school or less	Ref	—	Ref	—
Some college or more	1.17 (0.97 to 1.41)	0.10	1.11 (0.91 to 1.36)	0.29
Drug abuse screening test-10				
Below moderate drug use	Ref	—	Ref	—
Above moderate drug use	0.78 (0.70 to 0.87)	<0.001	**0.81** (**0.66** to **0.99**)	**0.04**
Social support				
Low	Ref	—	Ref	—
High	1.32 (1.12 to 1.55)	0.001	**1.22** (**1.00** to **1.47**)	**0.05**
Ever experienced homelessness				
No	Ref	—	Ref	—
Yes	0.75 (0.67 to 0.83)	<0.001	0.85 (0.70 to 1.03)	0.10
Adverse childhood experiences				
Low adverse childhood experiences	Ref	—	Ref	—
High adverse childhood experiences	0.86 (0.73 to 1.01)	0.08	0.95 (0.79 to 1.14)	0.57
Currently using PrEP? (within the past 30 days)				
No	Ref	—	Ref	—
Yes	0.84 (0.69 to 1.03)	0.09	0.86 (0.69 to 1.06)	0.16

*All bolded entries represent adjusted estimates that were statistically significant at a 0.05 alpha level.

reclassified as PrEP-indicated when using the enhanced study criteria. Thus, overall, the prevalence of PrEP indication was 12% higher based on the enhanced study criteria compared with that in the CDC criteria. Those who were PrEP-indicated based on transgender women–specific criteria were more likely to be aged 30 years or older ($P = 0.004$) and were more likely to report low social support ($P = 0.04$) than those indicated by CDC criteria only. A greater percentage of these participants also had an income below the federal poverty level (52% vs. 42%) and more reported above moderate to severe drug use (41% vs. 33%); however, these differences were not statistically significant ($P = 0.06$ and $P = 0.08$, respectively).

In multivariable analyses, participants who were non-Hispanic/non-Latinx Black (aPR: 1.53, 95% CI: 1.28 to 1.83), Hispanic/Latinx (aPR: 1.76, 95% CI: 1.47 to 2.11), or other race (aPR: 1.39, 95% CI: 1.19 to 1.62) were more likely to be PrEP-indicated compared with those who were non-Hispanic/non-Latinx White. Those who reported moderate to severe drug use (aPR: 1.34, 95% CI: 1.19 to 1.52), lifetime homelessness (aPR: 1.15, 95% CI: 1.02 to 1.29), or a recent (within the past 3 months) occurrence of psychological violence (aPR: 1.19, 95% CI: 1.06 to 1.34) were more likely to be PrEP-indicated. Geographic location, participation in the online cohort, and education were inversely associated with PrEP indication (Table 3).

High Prevalence of Self-Perceived Low HIV Risk Among Those PrEP Indicated

Among the 504 participants with available data on self-perceived HIV risk and who were indicated for PrEP based on the study criteria, 55% perceived themselves as being of low or no risk of HIV infection (Table 4). This percentage remained the same after excluding participants who reported current PrEP usage (ie, PrEP use within the past 30 days). Being younger than 30 years (aPR: 1.26, 95% CI: 1.04 to 1.53) and having high social support (aPR: 1.22, 95% CI: 1.00 to 1.47) were associated with higher prevalence of self-perceived low or no HIV risk. Having moderate to severe drug use was associated with higher self-perceived HIV risk (aPR: 0.81, 95% CI: 0.66 to 0.99).

PrEP Care Continuum Among Transgender Women

Among the 611 participants who were indicated for PrEP based on study criteria, 83% were aware of PrEP (Fig. 1). Among those aware of PrEP, 38% had ever taken

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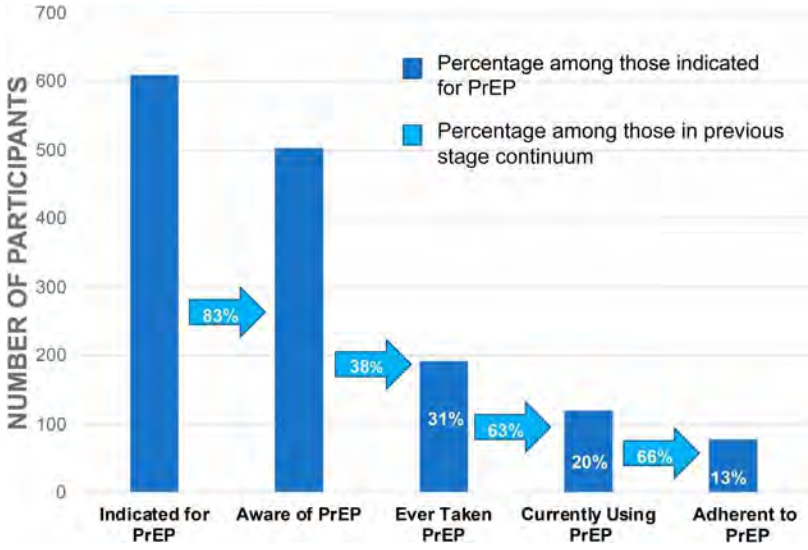

FIGURE 1. PrEP care continuum among participants with indications for PrEP based on LITE study criteria, May 2020. full color online

PrEP before the study. Sixty-three percent of those who had ever taken PrEP were using PrEP at the time of the study, and 66% of PrEP users reported 100% adherence within the previous 7 days of the survey (ultimately 13% of those indicated for PrEP). This summary of the PrEP care continuum was similar when using the CDC criteria (see Appendix, Supplemental Digital Content, http://links.lww.com/QAI/B673). There were 25 participants who reported using PrEP at the time of screening; however, they were not indicated for PrEP at the time of participation based on study criteria.

DISCUSSION

In this study, we found that there would be an additional 12% of study participants who would be PrEP-indicated using prescribing criteria specific to transgender women compared with those using the current CDC prescribing criteria. These participants could potentially benefit from PrEP if health practitioners used evidence-based PrEP indication criteria specific to the HIV risk factors of transgender women. This finding highlights the importance for health practitioners to become educated on these specific criteria to identify and prescribe PrEP to transgender women more efficiently. In addition, participants who were identified by transgender women–specific criteria for PrEP use were those who may experience greater risk environments because they had lower social support, higher levels of poverty, and higher substance use. Thus, using these specific prescribing criteria may identify transgender women subgroups with higher unmet need for PrEP. These findings suggest that guidelines must include criteria that are specific to transgender women (and other transgender or gender nonbinary individuals) to accurately determine PrEP indication in these populations and increase PrEP access among those who can benefit the most.

Being non-Hispanic/Latinx Black, Hispanic/Latinx, having above-average drug use, ever being homeless, or having a recent (within the past 3 months) occurrence of psychological violence were associated with a higher prevalence of PrEP indication. These factors (ie, racial and ethnic minority status, substance use, homelessness, and psychological violence) have also been shown in related literature to be associated with having less access to health care.[24,25] This lack of access would, thus, hinder transgender women from engaging with a health care professional who would be able to prescribe PrEP or even identify them as candidates for PrEP use.

The study also found a high proportion (more than half) of those indicated for PrEP had reported that they had no or low risk of acquiring HIV, even after analytically excluding participants who reported PrEP use. This is consistent with literature, which suggests that perceived susceptibility to HIV can be a critical barrier in the uptake of PrEP.[26] Factors associated with no or low HIV risk were reporting at younger age, greater educational levels, and high social support. Although younger age, higher levels of education, and high social support are factors traditionally associated with better health outcomes, HIV incidence is increasing faster among adolescents and young adults and are priority groups for HIV prevention.[27] Generally, these findings confirm the greater need for health practitioners to proactively engage with these patient populations and to increase opportunities for transgender women to learn about and access PrEP. PrEP interventions to improve HIV risk perceptions may benefit from reaching the social networks of younger age transgender women and those with high social support.

We also found that among all participants who had indications for PrEP, there was a low proportion currently using and adherent to daily, oral PrEP at the time of the study (13%). Although most participants with indications for PrEP were aware of PrEP (83%), only 38% had ever taken a medication regimen at the time of the study. Thus, there is a need for more PrEP implementation efforts among transgender women, including comprehensively identifying and counseling those who could most benefit from PrEP and exploring ways to support adherent usage once PrEP is prescribed.

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This study had several strengths and limitations. One of the strengths is that it uses one of the largest samples of transgender women (more than 1200) recruited across multiple metropolitan areas in the eastern and southern United States. Moreover, although there have been several studies exploring PrEP indications among transgender women, this is one of the only studies to explore the level of self-perceived low HIV risk among those who have indications for PrEP. One of the limitations of the data is that more than 100 participants with indications for PrEP did not report their "self-perceived" risk and were not included in this analysis. Although this represents less than 10% of the sample, study findings concerning factors associated with self-perceived low or no HIV risk may not reflect all participants with indications for PrEP. In addition, it is possible that the self-perceived HIV risk variable is misclassified because it was measured through self-report, and previous research suggests that respondents tend to underreport HIV risks.[28] Nonetheless, this further affirms the point that participants who may benefit from PrEP may not self-select themselves to seek care. In addition, although we included occurrence of sharing needles during injection drug use as part of criteria for study-specific PrEP indications, we did not include occurrences of sharing needles when injecting silicone, fillers, or when injecting hormones. However, we recommend to practitioners to consider any reported needle sharing practices when considering PrEP indication for transgender women.

CONCLUSIONS

This study found that expanding current CDC PrEP prescribing criteria to be specific to transgender women can identify a sizeable number of additional women who could benefit from PrEP. Both PrEP uptake and adherence, however, are low among transgender women who are indicated for PrEP, which is matched by low self-perceived risk of HIV acquisition. These findings highlight the need for transgender women to receive individualized PrEP recommendations and effective education concerning the benefits of PrEP to support PrEP uptake and adherence among those who need it the most.

ACKNOWLEDGMENTS

The authors thank the transgender women who took part in this study. This study would not have been possible without their participation. The authors also acknowledge the work of the entire American Cohort To Study HIV Acquisition Among Transgender Women team: Andrea Wirtz [multiple PI; Johns Hopkins University (JHU)]; Sari Reisner (multiple PI; Harvard University); Keri Althoff (JHU); Chris Beyrer (JHU); James Case (JHU); Erin Cooney (JHU); Oliver Laeyendecker (JHU); Megan Stevenson (JHU) and Jeffrey Herman (JHU); Tonia Poteat (University of North Carolina); Kenneth Mayer (Fenway Health); Asa Radix (Callen-Lorde Community Health Center); Christopher Cannon (Whitman-Walker Health); W. David Hardy (Whitman-Walker Institute); Jason Schneider (Emory University and Grady Hospital); Sonya Haw (Emory University and Grady Hospital); Allan Rodriguez (University of Miami); Andrew J. Wawrzyniak (University of Miami); the incredible research teams at each study site; and the LITE community advisory board, including the following individuals: Sherri Meeks, Flora Marques, Sydney Shackelford, Nala Toussaint, and SaVanna Wanzer and those who have remained anonymous.

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, December 22, 2022 12:35 PM PST
To: [redacted]@emory.edu>
Subject: Re: Request for Evaluator Letter: [redacted] MD, FACP, Emory University Promotion

Hi [redacted]

I'm unfortunately unable to accept. I am asked to write so many promotion letters that I am currently restricting myself to write such letters for people with whom I have had some direct contact.

Thanks for your understanding.

Sincerely,

Steve Rosenthal

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@emory.edu>
Sent: Thursday, December 22, 2022 11:35 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Request for Evaluator Letter: [redacted] MD, FACP, Emory University Promotion

This Message Is From an External Sender
This message came from outside your organization.

This email is being sent on behalf of Dr. [redacted] Interim Chair, Department of Medicine, Emory University School of Medicine

Dear Dr. Rosenthal,

You have been recommended as a highly qualified individual to evaluate the credentials o[redacted] **MD, FACP**, who is being considered for **promotion** to the rank of Full Professor, non-tenured in the Department of Medicine. We rely heavily on evaluations from distinguished individuals like yourself in the promotion process and hope you will be able to respond to this request. Although you may not be able to evaluate all aspects of Dr. Schneider's credentials, you may restrict your comments to those areas with which you are most familiar.

Because Dr. [redacted] is being considered for promotion in the **service** area of distinction, we are including relevant sections of our appointment and promotion guidelines for this action. Briefly, for promotion to Professor, non-tenured based on professional service, the candidate must have earned a national/international reputation OR demonstrate institutional/regional leadership in professional service, as well as at least substantial involvement in scholarship and at least institutional/regional achievement in teaching.

As part of our effort to expedite this process, we ask that you email [redacted] to let us know now whether or not you can provide an evaluation by Wednesday January 18, 2023. You may call [redacted] at [redacted] if you have any questions. Your response will be treated confidentially and will not be shared with the candidate.

If you are able to assist with this request, please click HERE to upload your evaluation letter which addresses the following:

1. Your relationship, if any, to the candidate, describing how you are familiar with the candidate's work. Previous mentors are not eligible to provide evaluations.
2. Candidate's accomplishments and impact in scholarship, teaching, and service.
3. Stature in the field relative to the candidate's cohorts.
4. Likelihood of promotion to this rank at your institution.
5. Whether you recommend this promotion based on our guidelines.

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Again, we would appreciate your letter by **Wednesday January 18, 2023**.
Your response is very important to us, and we are deeply grateful for your participation in this process.

Sincerely,
[redacted]

EMORY UNIVERSITY SCHOOL OF MEDICINE
Department of Medicine

[redacted] | Sr. Program Coordinator
Office of Faculty Development
[redacted]@emory.edu
1364 Clifton Road NE, Suite H-153 Atlanta, GA 30322
[redacted]
www.medicine.emory.edu

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From: [redacted]@emory.edu>
Sent: Thursday, December 22, 2022 12:43 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: [External] Re: Request for Evaluator Letter: [redacted], Emory University Promotion
Attachment(s): "image001.jpg"

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We appreciate you letting us know, Dr. Rosenthal.
Thank you.

Happy holidays.

Regards,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, December 22, 2022 3:35 PM
To: [redacted]@emory.edu>
Subject: [External] Re: Request for Evaluator Letter: [redacted], Emory University Promotion

Hi [redacted],

I'm unfortunately unable to accept. I am asked to write so many promotion letters that I am currently restricting myself to write such letters for people with whom I have had some direct contact.

Thanks for your understanding.

Sincerely,

Steve Rosenthal

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@emory.edu>
Sent: Thursday, December 22, 2022 11:35 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Request for Evaluator Letter: [redacted], Emory University Promotion

This Message Is From an External Sender
This message came from outside your organization.

This email is being sent on behalf of [redacted], Emory University School of Medicine

Dear Dr. Rosenthal,

Obtained via CPRA by Judicial Watch, Inc.

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You have been recommended as a highly qualified individual to evaluate the credentials o[redacted], who is being considered for **promotion** to the rank of Full Professor, non-tenured in the Department of Medicine. We rely heavily on evaluations from distinguished individuals like yourself in the promotion process and hope you will be able to respond to this request. Although you may not be able to evaluate all aspects of [redacted] credentials, you may restrict your comments to those areas with which you are most familiar.

Because [redacted] is being considered for promotion in the **service** area of distinction, we are including relevant sections of our appointment and promotion guidelines for this action. Briefly, for promotion to Professor, non-tenured based on professional service, the candidate must have earned a national/international reputation OR demonstrate institutional/regional leadership in professional service, as well as at least substantial involvement in scholarship and at least institutional/regional achievement in teaching.

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If you are able to assist with this request, please click HERE to upload your evaluation letter which addresses the following:

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- Candidate's accomplishments and impact in scholarship, teaching, and service.
- Stature in the field relative to the candidate's cohorts.
- Likelihood of promotion to this rank at your institution.
- Whether you recommend this promotion based on our guidelines.

Again, we would appreciate your letter by **Wednesday January 18, 2023.**
Your response is very important to us, and we are deeply grateful for your participation in this process.

Sincerely,
[redacted]

EMORY UNIVERSITY SCHOOL OF MEDICINE
Department of Medicine
[redacted]
Office of Faculty Development
[redacted]@emory.edu
1364 Clifton Road NE, Suite H-153 Atlanta, GA 30322
[redacted]
www.medicine.emory.edu

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, December 22, 2022 1:44 PM PST
To: [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>; [redacted]@nclrights.org>
CC: Ha, Won <Won.Ha@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Fw: Letter from Rep. Foxx to UCSF Benioff Children's Hospital San Fransisco
Attachment(s): "Letter to UCSF Benioff Childrens San Fransisco12.22.22 FINAL.pdf"

Hi [redacted] and [redacted]

[redacted]

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
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Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: Burke, Caitlin <Caitlin.Burke@mail.house.gov>
Sent: Thursday, December 22, 2022 1:31 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: Patient Relations <Patient.Relations@ucsf.edu>; Mitchell, Eli <Eli.Mitchell@mail.house.gov>; Schaumburg, Mandy <Mandy.Schaumburg@mail.house.gov>
Subject: Letter from Rep. Foxx to UCSF Benioff Children's Hospital San Fransisco

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Good Afternoon Dr. Rosenthal,

Please find a letter from Representative Virginia Foxx attached. Thank you for your attention to these requests.

Sincerely,
Caitlin

--
Caitlin Burke Miller
Professional Staff Member
Committee on Education and Labor Republicans

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December 22, 2022

Dr. Stephen M. Rosenthal
Medical Director
Child and Adolescent Gender Center
UCSF Benioff Children's Hospital San Francisco
1975 4th St.
San Francisco, CA 94158

Dear Dr. Rosenthal:

The family is the most basic unit of society and as such, "parents have the inalienable right and responsibility to educate and rear their children."[1] Unfortunately, there are people who want to override parents' decisions. Their efforts result in the erosion of parents' rights to make medical decisions for their children. And in some cases, those decisions have resulted in parents losing all rights when it comes to their children.

Child protective services (CPS) has taken children from the homes of loving parents because they do not support irreversible, life-altering surgeries and other medical interventions, such as cross-sex hormones, on their children diagnosed with gender dysphoria. For example, in California, Abigail Martinez lost custody of her daughter and a court permitted only one hour of visitation each week because Ms. Martinez did not want her daughter to receive gender-transition interventions.[2] In Illinois, Jeannette Cooper lost a custody battle with her ex-husband over their daughter's decision to receive gender-transition interventions.[3] And in 2018, a Cincinnati couple

[1] "Principles," American College of Pediatricians, accessed November 21, 2022, https://acpeds.org/about.
[2] Tori Richards, "Mother of trans teenager: Los Angeles County killed my daughter," *Washington Examiner*, March 22, 2022, https://www.washingtonexaminer.com/news/mother-of-transgender-teenager-los-angeles-county-killed-my-daughter.
[3] Alec Schemmel, "Mother who questioned 12-year-old daughter's gender transition loses custody battle," *The National Desk*, August 1, 2022, https://fox17.com/news/nation-world/mother-who-questioned-12-year-old-daughters-gender-transition-loses-custody-battle.

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lost custody of their 17-year-old daughter because they would not consent to cross-sex hormones.[4]

Your website states, "The UCSF Child and Adolescent Gender Center (CAGC) offers comprehensive medical and psychological care, as well as advocacy and legal support, to transgender, nonbinary and gender-diverse children and adolescents. We bring together experts from both UCSF and elsewhere to promote gender health and positive outcomes for children and adolescents exploring gender identity and expression. The CAGC accepts new patients ages 3 through 17. Prior to the onset of puberty, our care focuses strictly on social and emotional development and we don't offer gender-affirming medical treatments. Once a patient reaches puberty, gender-affirming medical treatments may be considered following a thorough mental health assessment by a gender specialist."[5] We further note that the hospital does not perform surgeries on pre-adolescent or newly adolescent children but does "refer older adolescents or young adults who are considering gender-affirming surgery to medical providers outside the CAGC."[6]

I would like to understand more about how parents are involved in these conversations and about the medical services or therapy they are offered to consider for their child prior to consenting to life-altering medical interventions. Parents have the right and responsibility to make medical decisions for their children, and they should be free to do so without undue pressure or negative interference from medical establishments.

I have concerns about the use of life-altering, irreversible medical interventions on children with healthy bodies. Further, I want to ensure parents are a key part of any medical decisions for their children. Parents have the right and responsibility to make medical decisions for their children, and they should be free to do so without undue pressure or interference from medical establishments.

To help me understand how you engage with parents and their children in these matters, please respond to the following questions and requests within two weeks of receipt of this letter:

1. Has UCSF Benioff Children's San Fransisco ever delivered medical interventions for a minor diagnosed with gender dysphoria whose parents have objected to such interventions?

2. Has UCSF Benioff Children's San Fransisco ever provided a vaginoplasty, metoidioplasty, phalloplasty, chest reconstruction, breast augmentation, facial feminization, or facial masculinization to a child over the objection of one or both parents?

---

[4] Kevin Grasha, "Judge throws out lawsuit by parents of transgender teen held at Children's Hospital," *Cincinnati Enquirer*, November 21, 2018, https://www.cincinnati.com/story/news/2018/11/21/federal-judge-throws-out-lawsuit-parents-transgender-teen/2077892002/.

[5] "Child & Adolescent Gender Center," University of California San Francisco Benioff Children's Hospitals, accessed November 21, 2022, https://www.ucsfbenioffchildrens.org/clinics/child-and-adolescent-gender-center.

[6] "Child & Adolescent Gender Center," University of California San Francisco Benioff Children's Hospitals, accessed November 21, 2022, https://www.ucsfbenioffchildrens.org/clinics/child-and-adolescent-gender-center.

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3. Please provide a summary of the policies and protocol(s) used to consult with parents when parents of minors, or minors themselves, contact the hospital for services related to a possible gender dysphoria diagnosis or a desire for "gender-affirming care." Please also include a copy of the consent form(s) used for such services (including for puberty blockers, estrogen or feminizing medications, testosterone or masculinizing medications, progesterone or other progestogens, and surgeries) the timing or juncture at which consent is obtained, including whether consent is obtained anew before escalating to a new treatment phase (for example, if clinicians recommend the introduction of cross-sex hormones to a child currently receiving GnRHA treatments), and please note whether each form is for the child, parent, or both.

4. Please list how many, if any, reports or inquires hospital staff have made to child protective services regarding a child presenting for, or currently receiving, "gender-affirming care."

5. Please list how many, if any, reports or inquiries hospital staff have made to CPS in response to a parent (or parents) who will not consent to medical interventions that would hormonally or surgically transition their child.

6. Please describe the hospital's process for handling a case if parents do not agree with a doctor's recommended plan of care for their child diagnosed with gender dysphoria. Please also describe the hospital's process for handling a case in which two parents share custody of their child, but only one parent agrees with a doctor's recommended plan of care for his or her child diagnosed with gender dysphoria.

7. Please describe the hospital's process for handling a case if a parent refuses (or both parents refuse) to consent to medical or surgical interventions for purposes of gender transition desired by the child and/or recommended by the child's care providers.

8. Please describe the minimum number of mental health assessments and/or mental health therapy sessions the hospital requires a child to receive prior to undergoing medical or surgical interventions for purposes of gender transition. Also, please specify what types of clinicians are assessing and treating the patients (for example, licensed psychiatrists, psychologists, clinical social workers, behavioral health technicians, or other.) Are all the children and adolescents diagnosed with gender dysphoria diagnosed by either a licensed psychiatrist or psychologist, or are there other types of clinicians making the diagnoses? Please also specify whether such therapy sessions involve parents and, if so, what type of involvement with parents is required. For example, are parents required to consent to therapy sessions, to attend therapy sessions, to participate in family therapy sessions with the child, or to agree with or consent to a therapists' referral of the child for medical or surgical interventions before such interventions are performed?

9. Please provide the number of children you have seen at your hospital (including the gender clinic and surgical center) who have received cross-sex hormones from the hospital, the number who have received puberty blockers from the hospital, and the number who have obtained the surgeries listed above at the hospital. Additionally, please

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provide the number of children for whom the hospital, including the gender clinic, has provided puberty blockers, the number provided with referrals to obtain cross-sex hormones, and the number given referrals for vaginoplasty, metoidioplasty, phalloplasty, chest reconstruction, breast augmentation, facial feminization, or facial masculinization. Please include at what age the children in each of these categories have been given the referrals.

10. Please provide the number of children assessed for, diagnosed with, or treated for gender dysphoria by the hospital (including those seen in the gender clinic and those seen by other departments and assessed for, diagnosed with, or treated for gender dysphoria or referred for "gender-affirming treatments") who are under the ward of the state or under the guardianship of someone other than their parent(s). Please provide the number of children you have seen at your hospital whose parents both granted consent to their child's treatment at your hospital, the number of children you have seen where one parent granted consent to his or her child's treatment over the objection of the other parent, the number of children you have seen in which consent was obtained due to court intervention, and the number of children you have seen in which another guardian not listed here granted consent for the treatment.

We appreciate your prompt response to these requests.

Sincerely,

Virginia Foxx
Ranking Member
U.S. House Committee on Education and Labor

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, December 22, 2022 1:58 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@nclrights.org>
CC: Ha, Won <Won.Ha@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Letter from Rep. Foxx to UCSF Benioff Children's Hospital San Fransisco

[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, December 22, 2022 1:44 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted]@nclrights.org>
Cc: Ha, Won <Won.Ha@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Fw: Letter from Rep. Foxx to UCSF Benioff Children's Hospital San Fransisco

Hi [redacted] and [redacted]

[redacted]

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: Burke, Caitlin <Caitlin.Burke@mail.house.gov>
Sent: Thursday, December 22, 2022 1:31 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: Patient Relations <Patient.Relations@ucsf.edu>; Mitchell, Eli <Eli.Mitchell@mail.house.gov>; Schaumburg, Mandy <Mandy.Schaumburg@mail.house.gov>
Subject: Letter from Rep. Foxx to UCSF Benioff Children's Hospital San Fransisco

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Good Afternoon Dr. Rosenthal,

Please find a letter from Representative Virginia Foxx attached. Thank you for your attention to these requests.

Sincerely,
Caitlin

--
Caitlin Burke Miller
Professional Staff Member
Committee on Education and Labor Republicans

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CC: Ha, Won <Won.Ha@ucsf.edu>
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Hi all,

[redacted]

[redacted]
Senior Public Information Representative
UCSF Office of Communications

University of California, San Francisco
Cell/Text: [redacted]

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[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
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San Francisco, CA 94158
e-mail: [redacted].[redacted]@ucsf.edu

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Attachment(s): "Letter to UCSF Benioff Childrens San Fransisco12.22.22 FINAL.pdf"

[redacted]

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JOE SEMPOLINSKI, NEW YORK

December 22, 2022

Dr. Stephen M. Rosenthal
Medical Director
Child and Adolescent Gender Center
UCSF Benioff Children's Hospital San Francisco
1975 4th St.
San Francisco, CA 94158

Dear Dr. Rosenthal:

The family is the most basic unit of society and as such, "parents have the inalienable right and responsibility to educate and rear their children."[1] Unfortunately, there are people who want to override parents' decisions. Their efforts result in the erosion of parents' rights to make medical decisions for their children. And in some cases, those decisions have resulted in parents losing all rights when it comes to their children.

Child protective services (CPS) has taken children from the homes of loving parents because they do not support irreversible, life-altering surgeries and other medical interventions, such as cross-sex hormones, on their children diagnosed with gender dysphoria. For example, in California, Abigail Martinez lost custody of her daughter and a court permitted only one hour of visitation each week because Ms. Martinez did not want her daughter to receive gender-transition interventions.[2] In Illinois, Jeannette Cooper lost a custody battle with her ex-husband over their daughter's decision to receive gender-transition interventions.[3] And in 2018, a Cincinnati couple

[1] "Principles," American College of Pediatricians, accessed November 21, 2022, https://acpeds.org/about.
[2] Tori Richards, "Mother of trans teenager: Los Angeles County killed my daughter," *Washington Examiner*, March 22, 2022, https://www.washingtonexaminer.com/news/mother-of-transgender-teenager-los-angeles-county-killed-my-daughter.
[3] Alec Schemmel, "Mother who questioned 12-year-old daughter's gender transition loses custody battle," *The National Desk*, August 1, 2022, https://fox17.com/news/nation-world/mother-who-questioned-12-year-old-daughters-gender-transition-loses-custody-battle.

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lost custody of their 17-year-old daughter because they would not consent to cross-sex hormones.[4]

Your website states, "The UCSF Child and Adolescent Gender Center (CAGC) offers comprehensive medical and psychological care, as well as advocacy and legal support, to transgender, nonbinary and gender-diverse children and adolescents. We bring together experts from both UCSF and elsewhere to promote gender health and positive outcomes for children and adolescents exploring gender identity and expression. The CAGC accepts new patients ages 3 through 17. Prior to the onset of puberty, our care focuses strictly on social and emotional development and we don't offer gender-affirming medical treatments. Once a patient reaches puberty, gender-affirming medical treatments may be considered following a thorough mental health assessment by a gender specialist."[5] We further note that the hospital does not perform surgeries on pre-adolescent or newly adolescent children but does "refer older adolescents or young adults who are considering gender-affirming surgery to medical providers outside the CAGC."[6]

I would like to understand more about how parents are involved in these conversations and about the medical services or therapy they are offered to consider for their child prior to consenting to life-altering medical interventions. Parents have the right and responsibility to make medical decisions for their children, and they should be free to do so without undue pressure or negative interference from medical establishments.

I have concerns about the use of life-altering, irreversible medical interventions on children with healthy bodies. Further, I want to ensure parents are a key part of any medical decisions for their children. Parents have the right and responsibility to make medical decisions for their children, and they should be free to do so without undue pressure or interference from medical establishments.

To help me understand how you engage with parents and their children in these matters, please respond to the following questions and requests within two weeks of receipt of this letter:

1. Has UCSF Benioff Children's San Fransisco ever delivered medical interventions for a minor diagnosed with gender dysphoria whose parents have objected to such interventions?

2. Has UCSF Benioff Children's San Fransisco ever provided a vaginoplasty, metoidioplasty, phalloplasty, chest reconstruction, breast augmentation, facial feminization, or facial masculinization to a child over the objection of one or both parents?

---

[4] Kevin Grasha, "Judge throws out lawsuit by parents of transgender teen held at Children's Hospital," *Cincinnati Enquirer*, November 21, 2018, https://www.cincinnati.com/story/news/2018/11/21/federal-judge-throws-out-lawsuit-parents-transgender-teen/2077892002/.

[5] "Child & Adolescent Gender Center," University of California San Francisco Benioff Children's Hospitals, accessed November 21, 2022, https://www.ucsfbenioffchildrens.org/clinics/child-and-adolescent-gender-center.

[6] "Child & Adolescent Gender Center," University of California San Francisco Benioff Children's Hospitals, accessed November 21, 2022, https://www.ucsfbenioffchildrens.org/clinics/child-and-adolescent-gender-center.

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3. Please provide a summary of the policies and protocol(s) used to consult with parents when parents of minors, or minors themselves, contact the hospital for services related to a possible gender dysphoria diagnosis or a desire for "gender-affirming care." Please also include a copy of the consent form(s) used for such services (including for puberty blockers, estrogen or feminizing medications, testosterone or masculinizing medications, progesterone or other progestogens, and surgeries) the timing or juncture at which consent is obtained, including whether consent is obtained anew before escalating to a new treatment phase (for example, if clinicians recommend the introduction of cross-sex hormones to a child currently receiving GnRHA treatments), and please note whether each form is for the child, parent, or both.

4. Please list how many, if any, reports or inquires hospital staff have made to child protective services regarding a child presenting for, or currently receiving, "gender-affirming care."

5. Please list how many, if any, reports or inquiries hospital staff have made to CPS in response to a parent (or parents) who will not consent to medical interventions that would hormonally or surgically transition their child.

6. Please describe the hospital's process for handling a case if parents do not agree with a doctor's recommended plan of care for their child diagnosed with gender dysphoria. Please also describe the hospital's process for handling a case in which two parents share custody of their child, but only one parent agrees with a doctor's recommended plan of care for his or her child diagnosed with gender dysphoria.

7. Please describe the hospital's process for handling a case if a parent refuses (or both parents refuse) to consent to medical or surgical interventions for purposes of gender transition desired by the child and/or recommended by the child's care providers.

8. Please describe the minimum number of mental health assessments and/or mental health therapy sessions the hospital requires a child to receive prior to undergoing medical or surgical interventions for purposes of gender transition. Also, please specify what types of clinicians are assessing and treating the patients (for example, licensed psychiatrists, psychologists, clinical social workers, behavioral health technicians, or other.) Are all the children and adolescents diagnosed with gender dysphoria diagnosed by either a licensed psychiatrist or psychologist, or are there other types of clinicians making the diagnoses? Please also specify whether such therapy sessions involve parents and, if so, what type of involvement with parents is required. For example, are parents required to consent to therapy sessions, to attend therapy sessions, to participate in family therapy sessions with the child, or to agree with or consent to a therapists' referral of the child for medical or surgical interventions before such interventions are performed?

9. Please provide the number of children you have seen at your hospital (including the gender clinic and surgical center) who have received cross-sex hormones from the hospital, the number who have received puberty blockers from the hospital, and the number who have obtained the surgeries listed above at the hospital. Additionally, please

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provide the number of children for whom the hospital, including the gender clinic, has provided puberty blockers, the number provided with referrals to obtain cross-sex hormones, and the number given referrals for vaginoplasty, metoidioplasty, phalloplasty, chest reconstruction, breast augmentation, facial feminization, or facial masculinization. Please include at what age the children in each of these categories have been given the referrals.

10. Please provide the number of children assessed for, diagnosed with, or treated for gender dysphoria by the hospital (including those seen in the gender clinic and those seen by other departments and assessed for, diagnosed with, or treated for gender dysphoria or referred for "gender-affirming treatments") who are under the ward of the state or under the guardianship of someone other than their parent(s). Please provide the number of children you have seen at your hospital whose parents both granted consent to their child's treatment at your hospital, the number of children you have seen where one parent granted consent to his or her child's treatment over the objection of the other parent, the number of children you have seen in which consent was obtained due to court intervention, and the number of children you have seen in which another guardian not listed here granted consent for the treatment.

We appreciate your prompt response to these requests.

Sincerely,

Virginia Foxx
Ranking Member
U.S. House Committee on Education and Labor

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, December 22, 2022 2:25 PM PST
To: Ha, Won <Won.Ha@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
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[redacted]

[redacted]
Senior Public Information Representative

UCSF Office of Communications

University of California, San Francisco

Cell/Text: [redacted]

From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, December 22, 2022 1:58 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@nclrights.org>
Cc: Ha, Won <Won.Ha@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Letter from Rep. Foxx to UCSF Benioff Children's Hospital San Fransisco

[redacted]

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Thursday, December 22, 2022 1:44 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted]@nclrights.org>
Cc: Ha, Won <Won.Ha@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Fw: Letter from Rep. Foxx to UCSF Benioff Children's Hospital San Fransisco

Hi [redacted] and [redacted],

[redacted]

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Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: Burke, Caitlin <Caitlin.Burke@mail.house.gov>
Sent: Thursday, December 22, 2022 1:31 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: Patient Relations <Patient.Relations@ucsf.edu>; Mitchell, Eli <Eli.Mitchell@mail.house.gov>; Schaumburg, Mandy <Mandy.Schaumburg@mail.house.gov>
Subject: Letter from Rep. Foxx to UCSF Benioff Children's Hospital San Fransisco

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Good Afternoon Dr. Rosenthal,

Please find a letter from Representative Virginia Foxx attached. Thank you for your attention to these requests.

Sincerely,
Caitlin

--
Caitlin Burke Miller
Professional Staff Member
Committee on Education and Labor Republicans

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, December 23, 2022 3:02 PM PST
To: [redacted], [redacted] <[redacted].[redacted]@ucsf.edu>
Subject: Fwd: eRf # 83929

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, December 16, 2022 5:42 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: eRf # 83929

Not great news, but please keep us posted.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Friday, December 16, 2022 5:04 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: eRf # 83929

Wow, this is big news. Thank you for letting us know.

[redacted] **LCSW**
Pediatric Social Work Manager
UCSF Benioff Children's Hospital, San Francisco

Pediatric Social Work Department
1975 4th Street, Box 4012 | San Francisco, CA 94158
Office: 415.514-7668
Email [redacted]@ucsf.edu
Pronouns: she, hers, her, ella

UCSF Benioff Children's Hospitals

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From: [redacted]@ucsf.edu>
Sent: Friday, December 16, 2022 5:00 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: eRf # 83929

[redacted] Steve,

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I'll let [redacted] speak to the budgeted FTE.

But I did want to share that UCSF has officially implemented a hiring freeze given the significant budget deficit we're facing - this includes all new positions, replacement positions, posted positions, and temp requests. It's not entirely clear when we will have approval to move forward but I will continue to keep the group apprised as we receive additional insight. My apologies as I know this is disappointing news.

Thanks,

[redacted]

From: [redacted]@ucsf.edu>
Sent: Friday, December 16, 2022 4:52 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: eRf # 83929

Hi [redacted] and [redacted]

Steven and I would like to follow up on the status of the eRF for our Child and Adolescent Gender Clinic position. This is a replacement position for our previous SW, [redacted]. Since submitting the eRF in October, we have learned the FTE is actually .6 not .9. Ideally, we would really like to move forward with recruitment as soon as possible, so any information would be very much appreciated.

Thank you,

[redacted] **LCSW**
Pediatric Social Work Manager
UCSF Benioff Children's Hospital, San Francisco

Pediatric Social Work Department
1975 4th Street, Box 4012 | San Francisco, CA 94158
Office: 415.514-7668
Email: [redacted]@ucsf.edu
Pronouns: she. hers. her, ella

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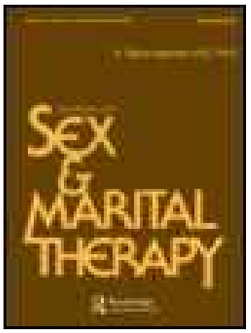

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Some Limitations of "Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist's View"

J. Cohn

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Some Limitations of "Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist's View"

J. Cohn

Society for Evidence-based Gender Medicine (SEGM), Twin Falls, ID, USA

ABSTRACT

There is significant disagreement about how to support trans-identified or gender-dysphoric young people. Different experts and expert bodies make strikingly different recommendations based upon the same (limited) evidence. The US-originating "gender-affirmative" model emphasizes social transition and medical intervention, while some other countries, in response to evidence reviews of medical intervention outcomes, have adopted psychological interventions as the first line of treatment. A proposed model of gender-affirming care, comprising only medical intervention for "eligible" youth, is described in Rosenthal (2021). Determining eligibility for these medical interventions is challenging and engenders considerable disagreement among experts, neither of which is mentioned. The review also claims without support that medical interventions have been shown to clearly benefit mental health, and leaves out significant risks and less invasive alternatives. The unreliability of outcome studies and the corresponding uncertainties as to how gender dysphoria develops and responds to treatment are also unreported.

KEYWORDS

Gender dysphoria; detransition; informed consent; exploratory therapy; affirmative model

Background

There has been a rapid rise in reported cases of gender dysphoria and trans-identified youth in the last few years (de Graaf, Giovanardi, Zitz, & Carmichael, 2018; Cass, 2021; American College Health Association, 2021). Gender dysphoria (GD) is a distressing condition that requires compassionate care (American Psychiatric Association, 2020), but neither gender dysphoria itself nor what constitutes best care are well understood. Gender dysphoria appears to have many different etiological influences, with biological, cultural, social, and psychological factors, and a variety of pathways to resolution (several presentations and pathways are shown in Figure 1, reproduced from the Cass Interim Report [Cass Review, 2022a, page 57]). It has been suggested that many forms of gender dysphoria exist, including childhood onset which typically resolves and is associated with adult homosexual orientation (Ristori & Steensma, 2016; Singh, Bradley, & Zucker, 2021), a condition (paraphilia) observed in older men (Blanchard, 1989; Bailey & Blanchard, 2017), and other less-understood presentations that appear to be associated with comorbid mental illness, autism spectrum disorders, trauma, or other mental health issues (Bockting, Knudson, & Goldberg, 2006; Churcher-Clarke & Spiliadis, 2019; Evans & Evans, 2021; Evans, 2022; Lemma, 2018; Parkinson, 2014; Withers, 2020).

Several interventions for gender dysphoria have been attempted with varying degrees of success, ranging from puberty blockers, hormones and surgery (Coleman et al., 2012; 2022; Hembree et al., 2017; Rafferty et al., 2018) to noninvasive holistic developmentally-informed care and

CONTACT J. Cohn jaycohn77@gmail.com Society for Evidence-based Gender Medicine (SEGM), Twin Falls, ID, USA.
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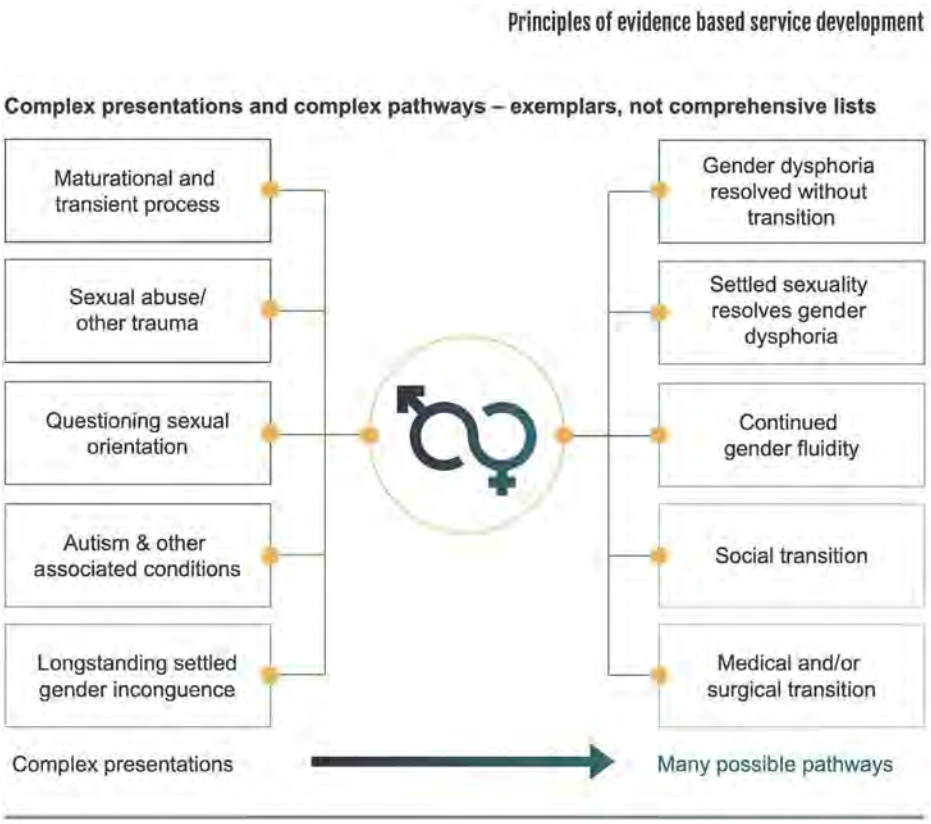

Figure 1. Examples of some different presentations and pathways for gender dysphoria, reproduced from the UK National Health Services commissioned Cass Interim Report (Cass Review, 2022a, page 57).

treatment of co-occurring mental health conditions (Ayad et al., 2022; Churcher-Clarke & Spiliadis, 2019; Evans & Evans, 2021; Evans, 2022; Parkinson, 2014; Schwartz, 2021; Withers, 2020). Simple progression of time, absent any intervention, has also been noted to lead to a resolution of gender dysphoria in many with childhood onset (Ristori & Steensma, 2016; Singh et al., 2021).

It is currently not possible to reliably estimate how any given individual case of gender dysphoria might proceed, with or without any specific intervention (Levine, Abbruzzese, & Mason, 2022). Even for the better studied childhood onset cases, there is no clinical test to reliably estimate the likelihood of persistence (Singh et al., 2021). For the quickly rising adolescent onset cohort (Kaltiala-Heino, Bergman, Työläjärvi, & Frisén, 2018, p. 31): "virtually nothing is known regarding adolescent onset GD, its progression and factors that influence the completion of the developmental tasks of adolescence among young people with GD and/or transgender identity." As a result of these uncertainties, what constitutes the best possible care for gender dysphoria is poorly understood and the subject of intense disagreement among professionals (Vrouenraets, Fredriks, Hannema, Cohen-Kettenis, & de Vries, 2015).

One approach is the "affirmative model," which routinely offers rapid social transition and medical intervention, i.e., puberty blockers, hormones and surgery (Rafferty et al., 2018, Table 2). This approach has become the prevailing model in the United States, where it originated (Cass Review, 2022a, p. 78), and was formally endorsed by the American Academy of Pediatrics (AAP) in 2018 (Rafferty et al., 2018). The AAP guidelines explain that gender affirmation "was formerly referred to as 'transitioning'" (Rafferty et al., 2018, p. 5), and, in practice, hormones or puberty blockers can even be prescribed at the first clinic visit (Terhune, Respaut, & Conlin, 2022). In contrast, on the heels of rigorous evidence reviews of medical intervention outcomes, detailed later, Finland (Council for Choices in Healthcare Finland (COHERE Finland), 2020),

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Sweden (Swedish National Board of Health & Welfare, 2022), the UK in their proposed guidelines (NHS England, 2022), and Florida in its proposed regulations (Ghorayshi, 2022) have turned to prioritizing mental health interventions instead, only recommending medical intervention for those under 18 after extensive evaluation, if at all. For example, the central UK pediatric gender clinic is now slated to be shut down due to safety and viability concerns, with the Cass Interim Report describing that staff felt "under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters" (Cass Review, 2022a, p. 17). A more holistic approach is now to be adopted (the Cass Review, [2022b] noted in follow-up that many they spoke with had different interpretations of terms related to gender affirming and exploratory therapeutic care). The French National Academy of Medicine (2022) has similarly advised caution and encouraged psychotherapy.

The striking difference between the two approaches to treating gender-distressed youth ("affirmation" featuring puberty blockers, hormones and surgeries versus noninvasive psychotherapy as the first line of treatment) and the seriousness of the medical interventions involved invites further scrutiny. In this paper, the available research evidence is compared to Rosenthal (2021), a recent review which "highlights key advances in our understanding of transgender and gender-diverse youth, the challenges of providing gender-affirming care, gaps in knowledge and priorities for research" (p. 581). His review is a suitable representative of the approach emphasizing medical intervention not only because of its breadth, prominence as a Nature review and wide impact (e.g., its role in legal proceedings [Amicus Brief of Medical Groups, 2022]), but also because Rosenthal coauthored both the Endocrine Society guidelines (Hembree et al., 2017) and one of the foundational papers outlining the gender-affirmative model (Hidalgo et al., 2013). Non-specialists and even specialist clinicians may lack sufficient time or expertise to disentangle the current expert disagreements; the aim of this evidence comparison is to help clinicians and others better navigate current research and inform their practice, as well as to educate patients directly.

Rosenthal (2021) presents a narrative for the development and treatment of trans-identification and gender dysphoria which rests on five key points, common in approaches emphasizing medical intervention. The first point presents the framing in terms of gender identity. The rest are stated as or implied to be facts, but are insufficiently supported by the evidence Rosenthal (2021) provides, and in some cases even in conflict with it or the evidence more broadly.

1. Gender identity underlies gender dysphoria and is a fundamental personal characteristic, suggested to be biologically "ingrained."
2. The current sharp rise of youth presenting with gender dysphoria does not correspond to an intrinsic rise in cases.
3. Care is medical intervention, with agreed upon eligibility criteria well supported by evidence.
4. Medical interventions have been demonstrated to be effective and safe.
5. Detransition does not represent medical harm and is rare.

These points are now elaborated in turn.

1. Gender identity underlies gender dysphoria and is a fundamental personal characteristic, suggested to be biologically "ingrained."

Rosenthal's (2021) assumptions regarding gender identity provide context for all five points listed above. He assumes gender dysphoria and trans-identification are due to a conflict between a person's gender identity and their body, with gender identity defined as "a person's fundamental, inner sense of self as male or female" which "is not always binary" (p. 582). He assumes this fundamental gender identity "can only be assumed and not known until

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an individual reaches a particular level of psychological development and self-awareness" (p. 582).

As would support a fundamental gender identity, Rosenthal (2021, p. 581) states there is "compelling evidence that biology contributes to gender identity development [3–16] (with the correlate that gender identity, like sexual orientation, is ingrained and not a 'choice')."

(The [3–16] refers to numbered references in Rosenthal, [2021] itself.) In support of a biological ingrained gender identity, Rosenthal (2021) provides genetic and neurological studies of people with gender dysphoria or trans-identification compared to people in the general population; however, these studies fall short. Some are confounded by including children (whose gender dysphoria is likely to abate [Ristori & Steensma, 2016; Singh et al., 2021]), not controlling for homosexuality (which does have some biological indicators), or having unusual and stereotypical definitions of gender (e.g., defining male gender as masculinity which is then taken to correspond to "aggressive, dominant, and independent" [Polderman et al., 2018, p. 102]). The others have too small samples (Marek et al., 2022), find nothing conclusive, or detect no signal. Rosenthal (2021) also presents endocrinological studies of disorders of sexual development (DSD), an entirely different condition with a well defined genetic or hormonal etiology, unlike gender dysphoria. As the vast majority of trans-identified people have no DSD, reliance on DSD studies and the endocrine differences in that population in order to claim an endocrine component to gender dysphoria is misleading. In sum, there is no currently available test (brain, DNA, or otherwise) that can reliably differentiate between a trans-identified and a non-trans identified person, which Rosenthal (2021) acknowledges: "(n)o currently available laboratory test can identify an individual's gender identity" (p. 581). Neither Rosenthal (2021) nor anyone else (see for instance, Frigerio, Ballerini, & Valdés Hernández, [2021]) has established the existence of a biologically "ingrained" gender identity.

If Rosenthal (2021) had shown his assumed fundamental gender identity to be biologically "ingrained," this might imply that gender identity, and thus trans-identification, was unalterable in general (unlike, say, a gender dysphoria case with a possible biological contribution). The well-known frequent resolution of childhood onset gender dysphoria (Ristori & Steensma, 2016; Singh et al., 2021) could be interpreted as an example where Rosenthal's (2021) assumed fundamental gender identity only becomes correctly known with maturity, so it is not necessarily in conflict with an unalterable fundamental gender identity. In contrast, other experts have suggested gender identity itself might change (Zucker, 2017). Even a reference Rosenthal (2021) cites for gender identity (Coleman et al., 2012) relies on another which claims "People vary in the intensity of their gender identification and in the permanence and completeness of this feeling. One's feelings of being a man and/or woman may fluctuate…" (Bockting, 1999, p. 3).

A biologically "ingrained" gender identity would appear to be in direct conflict with observations where gender dysphoria has resolved, either spontaneously, or with help of psychotherapy, at a variety of ages (Churcher-Clarke & Spiliadis, 2019; D'Angelo, 2018; Evans & Evans, 2021; Levine, 2018; Parkinson, 2014; Withers, 2020). More generally, these cases of transient gender dysphoria seem difficult to fit within Rosenthal's assumptions regarding gender identity and gender dysphoria.

2. The current sharp rise of youth presenting with gender dysphoria does not correspond to an intrinsic rise in cases

The "epidemic-like" rise (French National Academy of Medicine, 2022) of gender dysphoria in youth is viewed as an open puzzle (Cass, 2021; Swedish National Board of Health & Welfare, 2022), with questions being raised about possible relations to social contagion (Anderson, 2022a; 2022b; Littman, 2018; Marchiano, 2017). These suggested psychosocial influences do not appear to connect easily to the assumption of a fundamental (biologically "ingrained") gender identity.

In response to a psychosocial hypothesis that might help explain the rise, Rosenthal (2021) is dismissive. He refers to the hypothesis, that psychosocial factors can cause or contribute to

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the development of gender dysphoria in some individuals (Littman, 2018; 2021), as "a putative phenomenon" (p. 588). He repeats criticisms of the study (Littman, 2018) that generated this hypothesis, but not the rebuttals (Littman, 2020) of the criticisms. He then misleadingly states "(t)he above-noted methodological concerns prompted publication of a correction by the original author" (Rosenthal, 2021, p. 589) without mentioning that for the correction: "Other than the addition of a few missing values in Table 13, the Results section is unchanged in the updated version of the article" (Littman, 2019, p. 1). This psychosocial contribution hypothesis has since been bolstered by a peer reviewed study with first person reports (Littman, 2021).

Rosenthal's (2021) review sidesteps the challenge the psychosocial hypothesis may pose to his assumptions about gender identity, by presenting the rise in cases it addresses as neither a puzzle nor due to an actual rise in the numbers of those with gender dysphoria. He calls the rise "a notable change in our understanding of the TGD population" (p. 583), suggesting it is only the understanding, not the population, that is changing. He lists reasons for the rise (as fact) which describe why those with gender dysphoria might now be more likely to come forward or to be diagnosed, e.g., greater acceptance. These reasons are consistent with increased recognition of his assumed "fundamental" gender identities rather than the actual underlying number of cases changing (perhaps due to external influences). However, he does not show that his interpretation is better supported by the evidence than one which treats the rise in cases as intrinsic or some combination of the two. The potential validity of Littman's hypothesis, possible contribution to the rise in cases, and unclear relation to Rosenthal's (2021) hypothesized fundamental gender identity remain (Arnoldussen et al., 2022; French National Academy of Medicine, 2022).

3. Care is medical intervention, with agreed upon eligibility criteria well supported by evidence

A key component of Rosenthal's (2021) approach is his claim that one's fundamental gender identity can be accurately recognized upon reaching a requisite level of "psychological development and self-awareness" (p. 582). He appears to imply this level may be reached at or around pubertal onset, as he states (p. 585): "Longitudinal studies have indicated that the emergence or worsening of gender dysphoria with pubertal onset is associated with a very high likelihood of being a transgender adult."

Rosenthal (2021) explains that "this observation is central to the rationale for medical intervention in eligible transgender adolescents" (p. 585). His assumption of not only a fundamental but possibly "ingrained" gender identity can be seen here to have profound implications, as it frames irreversible medical intervention as a response to what he assumes is a fundamental (and in some interpretations of his approach, unchanging) personal characteristic.

However, beyond the fact that the general durability of Rosenthal's assumed gender identity (and corresponding trans-identification) has not been established, and appears in conflict with the evidence as mentioned earlier, the particular "central" observation to which Rosenthal (2021) refers is not supported by the paper he cites for it (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008). First of all, the authors focus on those with childhood onset, explicitly requiring it for medical interventions they discuss. They make no claim regarding outcomes for the distinct presentation of gender dysphoria "emerging" at pubertal onset. In addition, their own references do not establish that the behavior of gender dysphoria right when puberty begins determines how long gender dysphoria will continue, even for early onset gender dysphoria (Biggs, 2022b). Gender dysphoria present beyond puberty is not determinative either according to Cohen-Kettenis et al. (2008), as they describe a group of adolescents where gender dysphoria did not persist, who "after long term assessment (which, depending on the degree of gender dysphoria and nonrelated pathology, could take a year or even longer) were not deemed eligible for early treatment, and they did not pursue SR [genital surgery] at later ages" (p. 1894). Rosenthal's proposed milestone for identifying gender identity, upon which he claims medical intervention rests, is unsupported by the evidence he provides.

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A. Eligibility criteria and expert lack of consensus

In addition, the medical intervention eligibility to which Rosenthal (2021) refers is a major point of concern and disagreement among his expert colleagues. One of the most longstanding and important expert concerns in this field is avoiding medical intervention for those with transient gender dysphoria (creating "false positives" [Delemarre van de Waal & Cohen-Kettenis, 2006, p. S132; Terhune et al., 2022]). Thus the foundational (note the reliance upon it in Hembree et al., [2017]) Dutch Protocol for youth medical transition tried to lower the likelihood of false positives by requiring pre-pubertal, early onset dysphoria ("lifelong extreme" [Delemarre van de Waal and Cohen-Kettenis, 2006, p. S131]), psychological stability, a supportive environment, and a firm grasp of reality and the limits of transition (Delemarre van de Waal & Cohen-Kettenis, 2006; de Vries & Cohen-Kettenis, 2012). In addition, social transition before endocrinological intervention was discouraged, due to fears it would solidify gender dysphoria that would have otherwise resolved. Another approach to try to reduce false positives involves exploration of the possible contribution of mental health or other factors to a given person's gender dysphoria (Ayad et al., 2022; Edwards-Leeper & Anderson, 2021; Levine, 2021). There are medical intervention criteria as well in WPATH's 7th "standards of care" (Coleman et al., 2012) to which Rosenthal (2021) frequently refers, and in its update (Coleman et al., 2022). However, in a formal guideline review (Dahlen et al., 2021), ⅚ of the reviewers did not recommend the 2012 version (the last reviewer recommended only if modified) as a guideline, while the 2022 version is 'prone to bias' due to methods employed, with 'recommendations that cannot yet be relied upon' (Dahlen, Meads, & Bewley, 2022), and neither is "evidence-based" (Dahlen et al., 2022; Sinai, 2022).

Neither the Dutch protocol criteria nor any other have been shown to identify who might have good long-term outcomes without any medical and/or surgical interventions, who will require these interventions and who might be harmed by them. Thus the serious risk of medicalizing transient gender identity and creating false positives remains (Levine et al., 2022). Even though Rosenthal (2021) includes a section on ethical dilemmas, he makes no mention of this crucial uncertainty regarding eligibility for medical intervention and the accompanying dilemma it poses. These issues underlie much of the disagreement between experts, which he also does not mention.

B. Neglect of mental health interventions and assumption of minority stress

In line with implying eligibility for medical intervention can be clearly identified, Rosenthal (2021) equates his gender dysphoria "models of care" solely with medical intervention for those who are "eligible." (The only alternative to medical intervention that Rosenthal, [2021] appears to consider is no treatment, cautioning that the "stance of not intervening until more is known is not a neutral option" [p. 581].) Unsaid is that alternatives to "alignment of physical sex characteristics with gender identity" (p. 585) such as mental health interventions *are* sometimes successful at resolving gender dysphoria on their own. Even in Rosenthal's (2021) framing, such alternatives might be suitable for some of those "seeking medical services" mentioned at the beginning of the review, not all of whom can be assumed to be eligible for medical intervention. As several case studies link gender dysphoria to mental distress, autism spectrum disorders, etc. (Churcher-Clarke and Spiliadis, 2019; Evans, 2022; Withers, 2020), and given that a high fraction of young people currently present with comorbidities (Kaltiala-Heino et al., 2018), mental health based approaches might even be the most appropriate for many present-day gender dysphoria cases.

Instead, when touching on the topic of mental illness, Rosenthal (2021) steers readers away from its possible contributing role to gender dysphoria, saying that being transgender "should no longer be considered a mental illness" (p. 581). He connects mental health challenges and gender dysphoria in the opposite direction, stating that "many of the mental health challenges

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faced by transgender youth are not intrinsic to being transgender, but rather are a consequence of such youth not feeling accepted for who they are" (p. 585). This minority stress assumption for mental health concerns is part of the affirmative model: "if there is pathology, it more often stems from cultural reactions (e.g., transphobia, homophobia, sexism) rather than from within the child" (Hidalgo et al., 2013, p. 285). The minority stress assumption sidelines the critical clinical question of to "what extent GD may be a reaction to a range of preceding psychosocial stressors" (Thompson, Gillberg, Wilson, Sarovic, & Sämfjord, 2022, p. 26; see also Kozlowska, Chudleigh, McClure, Maguire, & Ambler, 2021; Levine et al., 2022). Rosenthal (2021) does note mental health evaluations may surface comorbidities, but then follows by suggesting how awareness and potential accessibility of medical intervention might have a positive impact: he does not mention that understanding the relation of these comorbidities to gender dysphoria may be relevant for determining suitable treatment (perhaps even revealing reasons to avoid medical intervention). Excluding consideration of underlying mental health issues as a possible developmental origin for gender dysphoria and suggesting only one source (minority stress) for mental health issues can create a bias that interferes with proper diagnosis, impeding or even precluding what may be the most appropriate treatment.

4. Medical interventions have been demonstrated to be effective and safe

Before turning to consequences of medical intervention, it is appropriate to first provide background regarding available evidence. Rosenthal (2021) mentions the "relative paucity of outcomes data" (p. 581) and that "long-term safety and efficacy studies are needed to optimize care" (p. 589), but it is not only that the quantity of studies that is low or that care is not optimized, it is also that the quality is so low that the ability to make reliable outcome estimates is compromised.

In his review, Rosenthal (2021) repeatedly refers to clinical guidelines and standards of care, which may give an impression of established, widely accepted, evidence-based protocols. The limitations of the WPATH guidelines (his "standards of care", although WPATH themselves refer to them as guidelines [WPATH, EPATH, USPATH, AsiaPATH, CPATH, AusPATH, & PATHA., 2020; Malone, Hruz, Mason, Beck, et al:, 2021]) are described above. The Endocrine Society guidelines (Hembree et al., 2017), to which Rosenthal (2021) also frequently refers, grade the evidence and report "low" and "very low" quality GRADE behind most of their own adolescent and childhood recommendations (three of the recommendations have ungraded supporting evidence, and moderate quality evidence backs the recommendation of counseling for fertility preservation). Low quality GRADE evidence means (Balshem et al., 2011, Table 2): "(o)ur confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect". Very low quality GRADE is defined as "very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect."

Other relevant evidence reviews have also been recently completed, some predating Rosenthal (2021) but not mentioned by him. The UK National Institute for Health and Care Excellence (NICE) evidence reviews (2020a; 2020b; focusing on under 18's) found the quality of evidence for puberty blockers and cross sex hormones on gender dysphoria, mental health and quality of life for gender dysphoric youth to be very low certainty using modified GRADE. Sweden has independently found the scientific evidence insufficient to assess safety or efficacy (Swedish National Board of Health & Welfare, 2022*)*, and after its own evidence review (Brignardello-Petersen & Wiercioch, 2022), Florida Medicaid (2022) concluded that "(t)he available medical literature provides insufficient evidence that sex reassignment through medical intervention is a safe and effective treatment for gender dysphoria." Likewise, a Cochrane review (Haupt et al., 2020, p. 2), "found insufficient evidence to determine the efficacy or safety of hormonal treatment approaches for transgender women in transition."

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A. Overstated mental health benefit of medical intervention

In spite of these low and very low quality/certainty evidence findings, Rosenthal (2021) describes the research evidence as "compelling" (p. 581), saying it has "confirmed" (p. 586) and "demonstrated" (p. 581; p. 586, twice) the "clear" (p. 581, twice; p. 582), even "life-saving" (p. 581, twice; p. 586), benefit of medical intervention. If gender identity were fundamental, and medical intervention eligibility determination accurate, such outcomes might be expected. However, as listed above, multiple rigorous evidence reviews have found the available research evidence too limited to reliably estimate outcomes. (In particular, "life-saving" is an inaccurate claim and raises concerns of suggesting suicide to vulnerable populations [Levine et al., 2022].) Even before his review appeared, several of the papers Rosenthal (2021) cites in support of his claims had already had their overall quality assessed as "poor" by the NICE evidence reviews (2020a; 2020b), and an attempt to reproduce one of his cited studies, de Vries, Steensma, Doreleijers, and Cohen-Kettenis (2011), had already failed (Carmichael et al., 2021). Two others of his cited papers do not show cause and effect (Becker et al., 2018; Turban, King, Carswell, & Keuroghlian, 2020) and thus cannot demonstrate that the interventions caused a given outcome. His remaining reference is the 2014 de Vries et al. report of outcomes for the Dutch Protocol. This study evaluated 55 young people at least one year past final surgery (Rosenthal's [2021, p. 586] "prospective 6-year follow-up study"), and does not support his strong claims of benefit either.

It is worth elaborating further regarding de Vries et al. (2014), given its prominence. As mentioned earlier, the Dutch Protocol criteria required psychological stability initially, and in this study participants continued to be psychologically stable, with a small mental health improvement. (However, ongoing mental health interventions might have confounded this result.) Their gender dysphoria was found to be much more improved after surgery, but this was confounded by de Vries et al. changing the evaluation questions after surgery. Before surgery, a natal girl would be asked how much they liked or hated being a girl and then, after surgery, how much they liked or hated being a boy (or vice versa for a natal boy), leading to a possible improvement just due to the change in assessment instrument (see more discussion in Levine et al., [2022]). Furthermore, the only Dutch Protocol long term study outcome that appears to be available is of the very first transitioned teen (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van deWaal, 2011); at 22 years past the start of the process he had "dissatisfaction and shame about his genital appearance" (p. 845). Thus, in spite of being the foundation upon which youth transition rests, the Dutch Protocol is highly incomplete (see also Biggs, [2022b] for more detailed analysis).

In addition, there is no reason to expect that even de Vries et al.'s (2014) limited outcomes would apply to the current clinical population, most of whom would violate one or more of the Dutch Protocol eligibility criteria listed earlier. That is, most have late (pubertal and post-pubertal) onset gender dysphoria, frequently present with co-morbid and untreated mental health problems (Kaltiala-Heino et al., 2018), have families which might be in conflict, and their expectations of medical transition are often not backed by reality. (For adults, mental health improvement has not been demonstrated either: in a large recent study, after reanalysis of the data and correction, no advantage was found for either hormones or surgeries for any of their outcome measures [Bränström & Pachankis, 2020a; 2020b].)

Claims of mental health benefit from medical intervention are also often used to argue that a randomized controlled study would be unethical. Rosenthal (2021) states: "While randomized controlled trials are often considered the gold standard, this approach to study hormonal interventions in TGD youth has not been considered feasible or ethical" (p. 588). While a randomized controlled trial might be difficult, for instance due to challenges in recruiting participants, it would not necessarily be unethical. The unethical thing may be the continuation of the "affirmative" medical and surgical path in light of all the questions and concerns that exist. A randomized controlled study would only be unethical if medical interventions were known to help and this is, despite Rosenthal's (2021) claims, not known.

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B. Adverse physical outcomes for medical intervention

For puberty blockers, there is a dearth of studies regarding their adverse effects when used to treat gender dysphoria, as Rosenthal (2021) notes. He reports some findings of bone mineral density harm (omitting a reanalysis [Biggs, 2021] which found worse outcomes), risks to fertility, and two inconclusive brain studies (one is a single case study finding an IQ drop of 10 points in 28 months). Rosenthal states that puberty blockers are "considered fully reversible" (p. 585), a commonly mentioned expectation based upon on-label use for precocious puberty, which may or may not carry over to off-label use with older gender dysphoric youth. However, he leaves unstated other adverse puberty blocker effects which similarly may or may not carry over from other uses, such as additional evidence for decreased IQ (Hayes, 2017; Mul et al., 2001), decreased male sexual desire (Turner & Briken, 2019), and (in animal studies) reduced maturity and long term impairment of spatial memory (Hough et al., 2017; 2019). If any such brain effects occur when treating gender dysphoria, they might interfere with a young person learning to make better decisions or better understand their body (Cass, 2022), perhaps undermining the frequently stated goal of using puberty blockers to "buy time."

For cross sex hormones, Rosenthal (2021) describes several of the risks as "mild", concluding there are "in general, no clinically significant adverse effects with gender-affirming sex hormones" (Box 2, p. 587). (At another point he qualifies this statement [p. 588].) He does recommend counseling and gives details about fertility preservation for those about to start puberty blockers or hormones, but does not otherwise mention the risks of hormones to fertility. Also left out are the the risk of impaired sexual function accompanying the atrophy and histological changes to gonads (Cheng, Pastuszak, Myers, Goodwin, & Hotaling, 2019), the associated harm to bone mineral density (Delgado-Ruiz, Swanson, & Romanos, 2019), the observed shrinkage of the hippocampus (Gomez et al., 2020; Holmes, 2016, Pol et al., 2006), associated significant increases seen in strokes, venous thromboembolic events, and heart attacks (Getahun et al., 2018; Nota et al., 2019), associated large increase in multiple sclerosis (Pakpoor et al., 2013), and possibly increased rates of depression (Fuss et al., 2015). In addition, testosterone can lead to pain from vaginal and uterine atrophy (Obedin-Maliver, 2016) and estrogen even has an FDA box warning, the strongest warning a drug can receive, for its on-label uses (National Academies of Sciences, Engineering, and Medicine, et al., 2020). A shorter lifespan is also observed (de Blok et al., [2021]; if followed by surgery, findings by Dhejne et al., [2011] are also relevant). Some of these omitted risks appear on consent forms (see for example those from the University of Iowa Hospitals and Clinics [n.d.a; n.d.b]) and some appear in the long term as part of the (expected) lifetime use of hormones; all of these potential adverse effects omitted by Rosenthal (2021) are relevant in order for a patient or their parents to give informed consent.

Rosenthal (2021) does note the medications are off-label (as a challenge to care), but of course, off-label means that the FDA has not established that benefits outweigh the risks when any of these medications are used to treat gender dysphoria. In fact, an evidence review for treatment of adolescents by the Swedish National Board of Health and Welfare (2022) found exactly the opposite: "The NBHW deems that the risks of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh the possible benefits, and that the treatments should be offered only in exceptional cases" (p. 3).

Detransition does not represent medical harm and is rare

Although Rosenthal (2021) mentions detransition, he does not mention that it might cause distress and even devastation. He presents only a positive anecdote of a single detransitioner, an adolescent who took puberty blockers for a year and then hormones for less than a year

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(Turban, Carswell, & Keuroghlian, 2018) and who "did not regret the decision […] feeling that their experience was vital to their consolidating their gender identity" (p. 586).

This benign detransition example is in stark contrast to the numerous detransitioner reports of debilitating regret found in the medical literature (D'Angelo, 2018; Evans, 2021; Withers, 2020) and online (Detrans Voices, n.d.). Sixty percent of the detransitioners in a recent peer reviewed study (a convenience sample [Vandenbussche, 2021]) reported needing help coping with feelings of regret and in Littman's (2021) convenience sample of detransitioners, "most respondents (64.6%) indicated that if they knew then what they know now, they would not have chosen to transition" (p. 3364). (Note that Vandenbussche, [2021] also included 31% social transitioners.) The increasing numbers of detransitioners and their reported distress are spurring many of the calls for more research and increased caution regarding medical interventions in youth (Butler & Hutchinson, 2020; Evans, 2021; Griffin, Clyde, Byng, & Bewley, 2021; Levine et al., 2022; Malone, 2021).

Rosenthal also refers to detransition as "rare" (p. 586), which might be expected to hold if eligibility for medical intervention was appropriately determined, but it is in fact currently unknown how often false positives occur, how often people regret, or how often people try to undo or stop their medical interventions or otherwise detransition (Levine et al., 2022). Rosenthal (2021) supports his assertion of rarity by saying there is a "relatively low" (p. 586) rate of discontinuation of medical intervention, citing studies which find those on puberty blockers tend to continue on to cross sex hormones. However, this says nothing about discontinuation rates of lifelong hormones. For instance, in one recent study, almost 30% of a group of teens and young adults who were receiving hormones appeared to discontinue them after 4 years (Roberts, Klein, Adirim, Schvey, & Hisle-Gorman, 2022). The discontinuation fraction in the group from this study might increase if followed up longer; for reference, depending on the sample population, medicalization criteria and intervention, the observed average or median observed times to regret or detransition in studies have ranged from 3 to 10 years (Dhejne, Öberg, Arver, & Landén, 2014; Littman, 2021; Vandenbussche, 2021; Wiepjes et al., 2018).

For specific numbers, Rosenthal (2021) quotes a problematic low reported regret rate after gonadectomy of less than 1% for adults at a single clinic (Wiepjes et al., 2018). This study measured regret by searching clinic records for those who both reversed hormones after gonadectomy *and* expressed regret. The study lost track of 36% of the clinic patients, as they stopped coming for their lifetime treatment (which treats 95% of those in the Netherlands). It is unknown if these 36% restarted hormones elsewhere or discontinued entirely; for this and other reasons the study authors point out that their regret number might be inaccurate. Nonetheless, Rosenthal (2021) quotes the <1% regret rate without including these qualifications.

More generally, regret underestimates are also likely because patients might not inform their clinicians; only 24% of detransitioners in Littman's (2021) convenience sample did so. Regret studies are often also inaccurate due to premature measurements of outcomes (sufficient time frames are suggested by the long observed regret times mentioned above), inappropriate measurement instruments and sample bias (D'Angelo, 2018; Expósito-Campos & D'Angelo, 2021). As detransition is a potential adverse outcome, it is important to report that the rate is unknown, rather than extremely small as claimed in Rosenthal (2021).

Discussion

Currently, there is a dramatic rise in the number of young people seeking help for gender dysphoria and/or reporting trans-identification. There is a dearth of understanding of both gender dysphoria and how to best support young people dealing with it; Rosenthal (2021) rightly recognizes there are "gaps in knowledge" (p. 589). Given the accompanying significant expert disagreements (including how to distinguish transient gender dysphoria), and one treatment option offering serious lifelong medical intervention with unclear outcomes and often irreversible consequences, decisions about treatment are fraught and ethical informed consent is crucial.

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Levine et al. (2022) discuss how properly informed consent for the care of gender dysphoric and trans-identified young people is currently impeded by "erroneous professional assumptions; poor quality of the initial evaluations; and inaccurate and incomplete information shared with patients and their parents."

These erroneous professional assumptions are in part caused by the many inaccurate or unsupported statements which have appeared in the peer-reviewed research literature, which often then get repeated and distorted (Clayton et al., 2021). For example, Cantor (2020) found that Rafferty et al. (2018) misrepresented their cited evidence in order to support the adoption of the affirmative model by the American Academy of Pediatrics. Above, many omissions and limitations in the Nature review by Rosenthal (2021) are discussed. These issues undercut the five key points upon which his review rests and could lead to inaccurate estimates of risks and benefits of medical intervention and a lack of awareness of (possibly more appropriate and less invasive) non-medical or psychiatric alternatives.

Many similar omissions and limitations are present in another review currently available only in preliminary form by Lee and Rosenthal (2023). This second review quotes additional references for evidence of benefit, including a double mastectomy study with a too short (1–5 year) follow up time, high loss (28%) to follow up and an unvalidated scale, for improvement of "chest dysphoria." In support of mental health improvement with medicalization, the second review quotes two additional recent papers which cannot show cause and effect (Green, DeChants, Price, & Davis [2022] and Turban, King, Kobe, Reisner, & Keuroghlian [2022], see Biggs, et al. [2022a] for discussion of further limitations of Turban et al. [2022]).

Beyond this second review, many of the issues highlighted in Rosenthal (2021) are in common with statements and policies espoused by others who also emphasize medical intervention (sometimes along with social transition). The US HHS office of Population Affairs (2022) and the American Academy of Pediatrics (Rafferty et al., 2018) also both fail to note that mental health or other noninvasive interventions may help gender dysphoria resolve even in the absence of medical intervention or social transition. Rosenthal's (2021) inaccurate claims that studies demonstrate mental health benefit of medical intervention are echoed widely (e.g, see the US HHS office of Population Affairs, [2022] and AusPATH, [2022]; the latter was rebutted by Clayton, et al., [2022]). The Endocrine Society (2020) position statement also downplays or omits many of the known serious physical dangers of medical intervention and also inaccurately claims evidence "demonstrating a durable biological element underlying gender identity" (see Malone, Hruz, Mason, Beck, et al. [2021] for a rebuttal of many of its points). The regret and detransition rates are also inaccurately claimed to be low in section 5.7 of WPATH's new version 8 guidelines (Coleman et al., 2022). These new version 8 WPATH guidelines also do not mention the NICE (2020a; 2020b) evidence reviews, similar to Rosenthal (2021); they also omit the Swedish (Swedish National Board of Health & Welfare, 2022) and Florida (Brignardello-Petersen & Wiercioch, 2022) evidence reviews appearing after Rosenthal (2021) and state: "Therefore, a systematic review regarding outcomes of treatment in adolescents is not possible. A short narrative review is provided instead" (Coleman et al., 2022, p. S46).

This direct comparison of evidence in the research literature with Rosenthal (2021), a review containing omissions and limitations also found in other prominent sources, may make it easier for practitioners, patients and their families to understand the current state of knowledge, including where uncertainties and controversies exist. In addition, it is hoped that more awareness of these uncertainties will increase support for follow-up studies of the large number of young people who have already begun lifetime medicalization, in order to capture outcomes at or beyond the observed average regret times, which range from 3 to 10 years in studies of different cohorts. Systematic outcome studies are badly needed. Similarly, the resolution of gender dysphoria via psychological intervention for some, who then avoid lifetime medicalization including risks to fertility, sexual function, and longevity, motivates support for studies to improve understanding and improvements to these non-medicalized and psychiatric approaches, and increased access to practitioners skilled in these methods (which may require increased training

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as well). And importantly, the substantial needs of detransitioners, a rapidly growing community, call for research as to how to help them, including psychological, medical and financial resources and community recognition and support.

There are serious challenges in deciding how to best support those currently suffering gender dysphoria, given how little is known about this complex condition. Accurately describing what the evidence currently says and does not say, and what further evidence is needed, is crucial.

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, December 27, 2022 9:42 AM PST
To: [redacted]@luriechildrens.org>
Subject: Re: Happy Holidays
Attachment(s): "Rosenthal SM Nature Reviews Endocrinology TGD Youth_ 10 August 2021.pdf"

Hi [redacted],

Yes--Already involved in what you referenced from the House...

Here's the PDF (peer-reviwed).

I hope you had a nice holiday.

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@luriechildrens.org>
Sent: Tuesday, December 27, 2022 9:35 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Happy Holidays

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Steve - If you would you mind sending me the PDF of the review this author is citing? I cannot access it.

Hope you are having some down time before clearly a bigger sh*t storm is about to come our way from a GOP House

Best,

[redacted]

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, December 27, 2022 11:13:19 AM
To: [redacted]@luriechildrens.org>; [redacted]@chla.usc.edu>; [redacted]@childrens.harvard.edu>; [redacted]@chop.edu>
Subject: Re: Happy Holidays

Nope. Hadn't seen this.
Steve

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From: [redacted]@luriechildrens.org>
Sent: Tuesday, December 27, 2022 6:01:21 AM
To: [redacted]@chla.usc.edu>; [redacted]@childrens.harvard.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@chop.edu>
Subject: Happy Holidays

You may have already seen this, but just thought I'd share. Written by an endocrinologist with no academic affiliation and a

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gmail account.

https://www.tandfonline.com/doi/pdf/10.1080/0092623X.2022.2160396?needAccess=true&role=button

[redacted]

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, December 27, 2022 9:46 AM PST
To: [redacted]@umn.edu>; [redacted]@emory.edu>; [redacted]@gmail.com>; [redacted]@nottingham.ac.uk>; [redacted]@univplastics.com>; [redacted]@aol.com>; [redacted]@doctors.org.uk>; [redacted]@gmail.com>
Subject: Re: these commentaries are irritating
Attachment(s): "Rosenthal SM Nature Reviews Endocrinology TGD Youth_ 10 August 2021.pdf"

Yes, I just saw it this morning. I've attached the PDF of my article (peer-reviewed). The commentator clearly does not agree with the science supporting gender-affirming care.

Steve

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550 16th St., 4th Floor, #4635
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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@umn.edu>
Sent: Tuesday, December 27, 2022 9:10 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@emory.edu>; [redacted]@gmail.com>; [redacted]@nottingham.ac.uk>; [redacted]@univplastics.com>; [redacted]@aol.com>; [redacted]@doctors.org.uk>; [redacted]@gmail.com>
Subject: Re: these commentaries are irritating

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Forgot the attachment!

On Tue, Dec 27, 2022 at 9:09 AM [redacted]@umn.edu> wrote:

> Many of you have seen this - but to the naive reader they can be compelling - and to us irritating.
>
> Happy New Year y'all!
>
> --
>
> [redacted] PhD.
> **Professor Emeritus**
> **The Institute for Sexual and Gender Health**
> University of Minnesota Medical School
> Family Medicine and Community Health
> med.umn.edu/sexualhealth

--

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[redacted], PhD.
Professor Emeritus
The Institute for Sexual and Gender Health
University of Minnesota Medical School
Family Medicine and Community Health
med.umn.edu/sexualhealth

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From: Rosenthal, Stephen
Sent: Tuesday, December 27, 2022 9:53 AM PST
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
CC: [redacted], [redacted] <[redacted], [redacted]@ucsf.edu>
Subject: CAGC Consent Forms

Hi [redacted]
Please email me a copy of all CAGC consent forms (blocker, estradiol, testosterone, "anti-androgen").

Hi [redacted]
It's my understanding that we recently made our CAGC medical intervention consent forms uniform across both BCH-SF and BCH-Oak. Can you confirm, and if the consent forms at BCH-Oak are different from those at BCH-SF, please send them to me.

Thank you both,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
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Pronouns: he/him/his

Director, World Professional Association for Transgender Health
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Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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From: [redacted]@gmail.com>
Sent: Tuesday, December 27, 2022 10:01 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
CC: [redacted]@umn.edu>; [redacted]@emory.edu>; [redacted]@nottingham.ac.uk>; [redacted]@univplastics.com>; [redacted]@aol.com>; [redacted]@doctors.org.uk>; [redacted]@gmail.com>
Subject: Re: these commentaries are irritating

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Thank you for sharing. I'm so tired of seeing these

On Tue, Dec 27, 2022, 12:47 PM Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu> wrote:

> Yes, I just saw it this morning. I've attached the PDF of my article (peer-reviewed). The commentator clearly does not agree with the science supporting gender-affirming care.
>
> Steve
>
> Stephen M. Rosenthal, M.D.
> Professor of Pediatrics
> Division of Pediatric Endocrinology
> Medical Director, Child and Adolescent Gender Center
> University of California, San Francisco
> Mission Hall: Global Health and Clinical Sciences
> 550 16th St., 4th Floor, #4635
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> Past President, Pediatric Endocrine Society
>
> Tel.: (415) 476-2266
> Fax: (415) 476-5356
> email: Stephen.Rosenthal@ucsf.edu
>
> ---
>
> **From:** [redacted]@umn.edu>
> **Sent:** Tuesday, December 27, 2022 9:10 AM
> **To:** Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@emory.edu>; [redacted]@gmail.com>; [redacted]@nottingham.ac.uk>; [redacted]@univplastics.com>; [redacted]@aol.com>; [redacted]@doctors.org.uk>; [redacted]@gmail.com>
> **Subject:** Re: these commentaries are irritating
>
> **This Message Is From an External Sender**
> This message came from outside your organization.
>
> Forgot the attachment!
>
> On Tue, Dec 27, 2022 at 9:09 AM [redacted]@umn.edu> wrote:
>
> > Many of you have seen this - but to the naive reader they can be compelling - and to us irritating.
> >
> > Happy New Year y'all!
> >
> > --
> >
> > [redacted] PhD.
> > **Professor Emeritus**
> > **The Institute for Sexual and Gender Health**
> > University of Minnesota Medical School
> > Family Medicine and Community Health
> > med.umn.edu/sexualhealth

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--

[redacted], PhD.
Professor Emeritus
The Institute for Sexual and Gender Health
University of Minnesota Medical School
Family Medicine and Community Health
med.umn.edu/sexualhealth

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From: [redacted]@luriechildrens.org>
Sent: Tuesday, December 27, 2022 10:07 AM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Happy Holidays

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Thank you!

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, December 27, 2022 11:42:52 AM
To: [redacted]@luriechildrens.org>
Subject: Re: Happy Holidays

Hi [redacted],

Yes--Already involved in what you referenced from the House...

Here's the PDF (peer-reviwed).

I hope you had a nice holiday.

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@luriechildrens.org>
Sent: Tuesday, December 27, 2022 9:35 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Happy Holidays

Steve - If you would you mind sending me the PDF of the review this author is citing? I cannot access it.

Hope you are having some down time before clearly a bigger sh*t storm is about to come our way from a GOP House

Best,

[redacted]

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, December 27, 2022 11:13:19 AM
To: [redacted]@luriechildrens.org>; [redacted]@chla.usc.edu>; [redacted]@childrens.harvard.edu>; [redacted]@chop.edu>
Subject: Re: Happy Holidays

Nope. Hadn't seen this.
Steve

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From: [redacted]@luriechildrens.org>
Sent: Tuesday, December 27, 2022 6:01:21 AM
To: [redacted]@chla.usc.edu>; [redacted]@childrens.harvard.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@chop.edu>
Subject: Happy Holidays

You may have already seen this, but just thought I'd share. Written by an endocrinologist with no academic affiliation and a gmail account.

https://www.tandfonline.com/doi/pdf/10.1080/0092623X.2022.2160396?needAccess=true&role=button

[redacted]

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, December 27, 2022 10:40 AM PST
To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]
[redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>
Subject: Re: CAGC SW Meeting

Hi [redacted]

Just made my comments on the form.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
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Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Tuesday, December 27, 2022 10:29 AM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: RE: CAGC SW Meeting

Hello everyone,

Below is a link to the questionnaire. Can you please make comments on the sections that you find essential to know, the ones you skip over, and the parts that are somewhat important? Thank you for your support in this process!

CAGC Questionnaire-With Edits.docx

Best,
[redacted]MSW
Clinical Social Worker
UCSF Benioff Children's Hospital
Child and Adolescent Gender Center

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.3809 / **fax:** 415.476.4748
pronouns: She/They

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From: [redacted]@ucsf.edu>
Sent: Saturday, December 17, 2022 1:23 PM
To: [redacted] <[redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>;
[redacted]@ucsf.edu>
Subject: CAGC SW Meeting

Hi everyone,
Thank you again for such a dynamic and productive meeting last week! It was such a pleasure to put names with faces and

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learn more about the impactful work you've all been doing for so many years.

For the sake of documentation, here's a summary of the main points we discussed...

1. The workload for J had become unmanageable, and this was likely due to a variety of factors, including increased patient load, a high volume of new patients (as opposed to ongoing/continuity patients), and some other provider shortages elsewhere in the clinic. Everyone is hopeful things will feel more manageable in general going forward.
2. Having a SW contact the family prior to their first visit is incredibly helpful for the treating team... getting a sense of the family's constellation, custody arrangement, disposition toward gender care, expectations for the visit, mental health history/treatment, etc have proven to be vitally important to making the most of the visit.
3. SW interventions are focused on the caregivers - however, the clinic espouses a family model of care, so there are opportunities for [redacted] (working alongside other team members) to also interact with patients, too, especially age 18+
4. The current assessment tool was developed by previous SW students, and while much of it is useful, there is room for revision. Expectation is that assessment does not need to be exceptionally time-consuming to capture essential information.
5. When CAGC makes its move to Pritzker (maybe February?), [redacted] will also move to Pritzker as her primary work place, and will be available to meet patients & families for initial and follow-up visits as needed.
6. Hope/goal is for SW to make the initial bond with families seeking care at the clinic, then remain available and visible as part of the interdisciplinary team to provide ongoing support as needed while patients/families access care

Our action items...

1. [redacted] will send out a blank assessment to all team members, with a request for them to indicate which questions they frequently "skip over," and which ones are vitally important for their first visit
2. [redacted] will take that feedback and meet with [redacted] to determine which information is appropriate for [redacted] to include in her conversation when she schedules patients (ie confirming demographic info, etc) and what information requires clinician-level assessment by [redacted]
3. With support of SW supervisors, [redacted] will draft an updated assessment format and send to this group for review.
4. Team will trial this new assessment format & structure over the next 3-6 months
5. [redacted] will send out a meeting request for ~4 months from now (with a zoom link attached!) to follow-up and re-assess this process.

I think this is it! Let me know what I missed, and thank you again for the teamwork.

Happy Holidays!
[redacted]

[redacted] LCSW
Chief Clinical Social Worker
UCSF Benioff Children's Hospital

UCSF Benioff Children's Hospitals
Pediatric Social Work
1975 4th Street, Room C5974, Box 4012
San Francisco, CA 94158
office: 415.502.4116 / **fax:** 415.476.4748
pronouns: She, Her, Hers

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, December 27, 2022 2:22 PM PST
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Meeting request

Hi [redacted]
1/13 in the window of noon-2 PM or 1/18 in the window of 1-4 PM (both Zoom) work if still open on [redacted] schedule.
Thanks,
Steve

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From: [redacted]@ucsf.edu>
Sent: Tuesday, December 13, 2022 10:44:44 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Meeting request

Hi Steve,

Please confirm if you can meet with [redacted] on these dates/times:

Mon 1/9: 10:00 AM – 12:00 PM – In person or Zoom
Tues 1/10: 10:00 AM – 11:00 PM – Zoom
Wed 1/11: 2:30 PM – 4:00 PM – Zoom
Thurs 1/12: 10:00 AM – 11:00 AM – Zoom
Fri 1/13: 12:00 PM – 2:00 PM – Zoom
Wed 1/18: 1:00 PM – 4:00 PM – Zoom
Mon 1/23: 10:00 AM – 11:00 AM – In person or Zoom
Wed 1/25: 1:00 PM – 4:00 PM – Zoom
Mon 1/30: 10:00 AM – 12:00 PM – In person or Zoom

Thank you and Happy Holidays!
[redacted]

Out of office: 12/15/22 - 1/2/23

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, December 13, 2022 8:27 AM
To: [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Meeting request

Hi [redacted]

I hope you are doing well! I'd like to set up a time to meet with you (in person or zoom) sometime in the next few weeks (January is fine!) to discuss my plans for the coming academic year.

Thanks and best wishes,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, December 28, 2022 9:30 AM PST
To: [redacted]@gmail.com>
CC: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Mexico city CATI [redacted]

Dear [redacted],

I apollogize for my delayed response, and I hope you had a nice holiday!

I have been informed by UCSF administrators that we are still not able to accept international in-person colleagues because of Covid restrictions. That being said, you would be very welcome to work with us by Zoom for our Telehealth Clinics. Our Child and Adolescent Gender Center (CAGC) clinic meets as a full team (with medical, mental health, and social work) on the 2nd, 3rd, and 4th Tuesdays each month. On those days, we begin with a 1-hour pre-clinic conference (from noon-1 PM, Pacific time), where we discuss the patients that are scheduled to be seen. We then have our clinic from 1-5 PM. I have cc'd our administrator, [redacted] who can let you know if any forms need to be completed in order for you to be able to observe during the actual clinic visits (if this is of interest to you). In addition, I have cc'd my cleeague, [redacted], PhD, Director of Mental Health for the CAGC. I, and I imagine, Dr. [redacted], would be happy to arrange a time to have a zoom call with you to talk about our interdisciplinary model of care.

With all best wishes, y Feliz Año Nuevo!

Steve

Stephen M. Rosenthal, M.D
Professor of Pediatrics
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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@gmail.com>
Sent: Friday, December 9, 2022 8:29 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Mexico city CATI [redacted]

Hello dr Rosenthal

I´m [redacted] we talked in the Endocrine Congress at Mérida, Mexico, I am the endocrinologist at CATI, Centro de Atención Transgénero Integral SC, a private institution, we have a little bit more of 700 transgender and non binary persons, we were talking about the possibility of me going there to visit you, or having this communication online connecting with you in your sessions. So just writing to know how can we start this dialogue. We also have dialogue with [redacted] at WPATH, so we are really interested in giving the best attention to our community, I'll send you our online site, just if you have some time to see also what we are doing. I appreciate your time.

https://urldefense.com/v3/__https://clinicatrans.org.mx/en__;!!LQC6Cpwp!oJ7!Urhb4Gdnd_Q4iOiD4ySsAgsWL3vEuBWGz7skVNZYUHICEDEpag_zUTZI3Ivp0FQVHzoX3NfPrXJUynqpvvk$

thank you

[redacted]

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, December 28, 2022 11:28 AM PST
To: [redacted]merritthawkins.com>
Subject: Re: Yale School of Medicine - Chief of Pediatric Endocrinology and Diabetes, seeking Applications/Nominations

Dear [redacted]

I apologize for my delayed response. I am happy with my professional employment and not currently looking for other options. In addition, I'm not aware of other candidates who might be interested and a good fit.

Thanks and best wishes,

Steve Rosenthal

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@merritthawkins.com>
Sent: Tuesday, December 6, 2022 11:21 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Yale School of Medicine - Chief of Pediatric Endocrinology and Diabetes, seeking Applications/Nominations

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Dear Dr. Rosenthal,

I am reaching out on behalf of the Department of Pediatrics at Yale University School of Medicine. We are in the midst of a national search for a new Chief of Pediatric Endocrinology and Diabetes. While assisting the search committee and in working with other leaders in your field, your name was provided to us as someone who would be a strong match for this opportunity, or someone in position to nominate others for this role. We encourage you to review the details below, and if possible, schedule a call to discuss further.

This is a wonderful opportunity to lead a program with a proud history of innovative contributions dating back to the 1950s. Today, the section consists of national and international leaders recognized for their contributions to endocrinology, diabetes, and pediatrics. The successful candidate will be a leader who will leverage existing strengths in the clinical, research, and education domains, taking this division to even greater heights.

- Yale's Pediatric Endocrinology and Diabetes Program has consistently ranked among the top 20 programs in the nation (*US News & World Report*)
- The division has enjoyed stable leadership for over 50 years
- Patient-oriented research has been the cornerstone of the division, with significant contributions on type 1 diabetes, obesity/type 2 diabetes, and bone metabolism
- In addition to having a robust clinical footprint for obesity and diabetes, the division is home to several interdisciplinary subspecialty programs: the pediatric metabolic bone program, the gender program, the differences in sexual development clinic, and the thyroid clinic
- Very active and highly regarded fellowship in Pediatric Endocrinology, with a total of six fellows

Additional details can be viewed in our formal positionprospectus. If you would be interested in discussing you can conveniently schedule a call with me by accessing a list of available times here[redacted]Calendar

If not personally interested, we would appreciate nominations and recommendations for this role*All inquiries will be confidential.*

Thank you for your time and consideration and I hope to hear from you soon.

Warm regards,
[redacted]

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[redacted]
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Office: [redacted]
[redacted]
MerrittHawkins.com
https://www.linkedin.com/[redacted]

To schedule a call/meeting: [redacted]

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From: Rosenthal, Stephen on behalf of Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, December 28, 2022 11:38 AM PST
To: [redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>
Subject: Re: [DoNotReply] November-2022 _ Award Verification _ Notification of Past Due Verifications Three Months Past Due

Hi [redacted]

I have opened the Award Verification tool and see a number of items with $ amounts. I'm not able to verify/confirm these numbers on my own. In the past, I have done this together with [redacted], no longer working with us. Please let me know when we can arrange a time together by zoom, where I can share my screen with you and you can hopefully help me with the verification process. Best times for me are the following: Tuesday, January 3rd sometime in the window of 9-11 AM and Wednesday, January 4th, sometime in the window of 2-4 PM.

Thanks, and happy new year!

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Thursday, December 15, 2022 12:59 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: [DoNotReply] November-2022 _ Award Verification _ Notification of Past Due Verifications Three Months Past Due

Hi Dr. Rosenthal,

Please let me know if you have any questions.

Thank you,

[redacted]

From: Award Verification Escalation <AwardVerificationEscalation@ucsf.edu>
Sent: Thursday, December 15, 2022 12:50 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: [DoNotReply] November-2022 _ Award Verification _ Notification of Past Due Verifications Three Months Past Due

Hi Award Verification Reporting Community,

This is anAward Verification Escalation notification of Past Due Award Verifications (AV) of more than three months. Principal Investigators (PI) are required to verify awards at least quarterly.

Please review your current portfolio in Award Verification and take the necessary actions to have all overdue awards verified before 01/08/2023.

['124096A', '126879A', '129809A', '133269A', '138395A']

The Award Verification Tool is accessed viaMyAccess. If you have issues signing on or other technical issues, please contact the IT Help Desk at 415-514-4100, option 2.

If you have any question regarding this notification, please send it toCGAServiceDesk@ucsf.edu and subject should be

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Award Verification.

High Risk

Award Verification Escalation Table	
Verification Status	Action
One month late	Notify Award Principal Investigator (PI) and Research Services Analyst (RSA)
Two months late	Notify Department Financial Administrator (DFA) with copy to Award PI and RSA
Three months late	Notify Department Chair with copy to DFA, Award PI and RSA
Four months late	CGA will move the charges associated with all unverified awards that have not been granted an extension by CGA following the CGA Default Discretionary Journal Procedure and notify Department Chair, DFA, Award PI, and RSA

Your cooperation and assistance are greatly appreciated.

Best regards,

CGA Compliance Team

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From: [redacted]@merritthawkins.com>
Sent: Wednesday, December 28, 2022 12:40 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
CC: [redacted]@merritthawkins.com>
Subject: RE: Yale School of Medicine - Chief of Pediatric Endocrinology and Diabetes, seeking Applications/Nominations

This Message Is From an External Sender
This message came from outside your organization.

Thank you for your email, Dr. Rosenthal.

Best wishes for you and a happy new year.

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, December 28, 2022 1:28 PM
To: [redacted]@merritthawkins.com>
Subject: Re: Yale School of Medicine - Chief of Pediatric Endocrinology and Diabetes, seeking Applications/Nominations

WARNING: This email came from outside of our trusted email system**DO NOT CLICK**links or attachments if you find the email suspicious.

Dear [redacted]

I apologize for my delayed response. I am happy with my professional employment and not currently looking for other options. In addition, I'm not aware of other candidates who might be interested and a good fit.

Thanks and best wishes,

Steve Rosenthal

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

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Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@merritthawkins.com>
Sent: Tuesday, December 6, 2022 11:21 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Yale School of Medicine - Chief of Pediatric Endocrinology and Diabetes, seeking Applications/Nominations

This Message Is From an External Sender
This message came from outside your organization.

Dear Dr. Rosenthal,

I am reaching out on behalf of the Department of Pediatrics at Yale University School of Medicine. We are in the midst of a national search for a new Chief of Pediatric Endocrinology and Diabetes. While assisting the search committee and in working with other leaders in your field, your name was provided to us as someone who would be a strong match for this opportunity, or someone in position to nominate others for this role. We encourage you to review the details below, and if possible, schedule a call to discuss

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further.

This is a wonderful opportunity to lead a program with a proud history of innovative contributions dating back to the 1950s. Today, the section consists of national and international leaders recognized for their contributions to endocrinology, diabetes, and pediatrics. The successful candidate will be a leader who will leverage existing strengths in the clinical, research, and education domains, taking this division to even greater heights.

- Yale's Pediatric Endocrinology and Diabetes Program has consistently ranked among the top 20 programs in the nation (*US News & World Report*)
- The division has enjoyed stable leadership for over 50 years
- Patient-oriented research has been the cornerstone of the division, with significant contributions on type 1 diabetes, obesity/type 2 diabetes, and bone metabolism
- In addition to having a robust clinical footprint for obesity and diabetes, the division is home to several interdisciplinary subspecialty programs: the pediatric metabolic bone program, the gender program, the differences in sexual development clinic, and the thyroid clinic
- Very active and highly regarded fellowship in Pediatric Endocrinology, with a total of six fellows

Additional details can be viewed in our formal position prospectus. If you would be interested in discussing you can conveniently schedule a call with me by accessing a list of available times here: [redacted] Calendar

If not personally interested, we would appreciate nominations and recommendations for this role*All inquiries will be confidential.*

Thank you for your time and consideration and I hope to hear from you soon.

[redacted]

[redacted]
Regional Vice President - Academics
Physician and Leadership Solutions- Permanent Placement

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[redacted]
[redacted]
MerrittHawkins.com
https://www.linkedin.com/in/jaytorio

To schedule a call/meeting [redacted] Calendar

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From: [redacted]@gmail.com [redacted]@gmail.com>
Sent: Wednesday, December 28, 2022 3:05 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Re: Mexico city CATI[redacted]

This Message Is From an Untrusted Sender
You have not previously corresponded with this sender.

Hello!!

Yes it would be spectacular to be connected with your telehealth clinic, really would love that, so yes I will wait for the email if there is anything you need to procede for this approach, and if it could be ok, also for my two psychiatrist of the clinic to join into this meetings. Really hope to hear from you real soon, so we can have an excellent new year!

Hope you have great end of year and an excellent new year!!

[redacted]

[redacted]
Director Médico Centro de Atención Transgénero Integral
Neuroendocrino
Endocrino
Medicina interna

El 28 dic 2022, a la(s) 11:31, Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu> escribió:

Dear [redacted]

I apollogize for my delayed response, and I hope you had a nice holiday!

I have been informed by UCSF administrators that we are still not able to accept international in-person colleagues because of Covid restrictions. That being said, you would be very welcome to work with us by Zoom for our Telehealth Clinics. Our Child and Adolescent Gender Center (CAGC) clinic meets as a full team (with medical, mental health, and social work) on the 2nd, 3rd, and 4th Tuesdays each month. On those days, we begin with a 1-hour pre-clinic conference (from noon-1 PM, Pacific time), where we discuss the patients that are scheduled to be seen. We then have our clinic from 1-5 PM. I have cc'd our administrator, [redacted] who can let you know if any forms need to be completed in order for you to be able to observe during the actual clinic visits (if this is of interest to you). In addition, I have cc'd my cleeague, [redacted], PhD, Director of Mental Health for the CAGC. I, and I imagine, Dr. [redacted], would be happy to arrange a time to have a zoom call with you to talk about our interdisciplinary model of care.

With all best wishes, y Feliz Año Nuevo!

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@gmail.com>
Sent: Friday, December 9, 2022 8:29 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Mexico city CATI[redacted]

Hello dr Rosenthal

I'm [redacted]we talked in the Endocrine Congress at Mérida, Mexico, I am the endocrinologist at CATI, Centro de Atención Transgénero Integral SC, a private institution, we have a little bit more of 700 transgender and non binary persons, we were talking about the possibility of me going there to visit you, or having this communication online connecting with you in your sessions. So just writing to know how can we start this dialogue. We also have dialogue with [redacted] at WPATH, so we are really interested in giving the best attention to our community, I'll send you our online site, just if you have some time to see also what we are doing. I appreciate your time.

https://urldefense.com/v3/__https://clinicatrans.org.mx/en__;!!LQC6CpwpIoJ7IUrhb4Gdnd_Q4iOiD4ySsAgsWL3vEuBWGz7skVNZYUHICEDEpag_zUTZI3Ivp0FQVHzoX3NfPrXJUynqpvvk$

thank you

[redacted]

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From: [redacted]@ucsf.edu>
Sent: Wednesday, December 28, 2022 6:40 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
CC: [redacted]@ucsf.edu>
Subject: RE: [DoNotReply] November-2022 _ Award Verification _ Notification of Past Due Verifications Three Months Past Due

Hi Dr. Rosenthal,

I will go ahead and send an invite for Tuesday, January 3rd.

Thank you and Happy New Year,
[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, December 28, 2022 11:39 AM
To: [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>
Subject: Re: [DoNotReply] November-2022 _ Award Verification _ Notification of Past Due Verifications Three Months Past Due

Hi [redacted]

I have opened the Award Verification tool and see a number of items with $ amounts. I'm not able to verify/confirm these numbers on my own. In the past, I have done this together with [redacted], no longer working with us. Please let me know when we can arrange a time together by zoom, where I can share my screen with you and you can hopefully help me with the verification process. Best times for me are the following: Tuesday, January 3rd sometime in the window of 9-11 AM and Wednesday, January 4th, sometime in the window of 2-4 PM.

Thanks, and happy new year!

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
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Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Thursday, December 15, 2022 12:59 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: RE: [DoNotReply] November-2022 _ Award Verification _ Notification of Past Due Verifications Three Months Past Due

Hi Dr. Rosenthal,

Please let me know if you have any questions.

Thank you,
[redacted]

From: Award Verification Escalation <AwardVerificationEscalation@ucsf.edu>
Sent: Thursday, December 15, 2022 12:50 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>

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Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: [DoNotReply] November-2022 _ Award Verification _ Notification of Past Due Verifications Three Months Past Due

Hi Award Verification Reporting Community,

This is an Award Verification Escalation notification of Past Due Award Verifications (AV) of more than three months. Principal Investigators (PI) are required to verify awards at least quarterly.

Please review your current portfolio in Award Verification and take the necessary actions to have all overdue awards verified before 01/08/2023.

['124096A', '126879A', '129809A', '133269A', '138395A']

The Award Verification Tool is accessed via MyAccess. If you have issues signing on or other technical issues, please contact the IT Help Desk at 415-514-4100, option 2.

If you have any question regarding this notification, please send it to CGAServiceDesk@ucsf.edu and subject should be Award Verification.

High Risk

Award Verification Escalation Table	
Verification Status	Action
One month late	Notify Award Principal Investigator (PI) and Research Business Analyst (RBA)
Two months late	Notify Department Financial Administrator (DFA) with copy to Award PI and RBA
Three months late	Notify Department Chair with copy to PI, Award PI and RBA
Four months Late	CGA will move the charges associated with an expiration awards that have not been updated as necessary by CGA following the Close Award Unnecessary Journal Procedure and notify Department Chair, DFA, Award PI, and RBA

Your cooperation and assistance are greatly appreciated.

Best regards,

CGA Compliance Team

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[redacted]

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Friday, January 22, 2021 1:57 PM
To: [redacted]@gmail.com>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: Re: Follow up - article request

Hi [redacted]

I have attached the article we discussed. I do not in any way consider myself an expert on this type of study, and not sure how to answer your questions in the second paragraph. My understanding is that gender identity "lives" in the brain, and may sometimes develop in a way that is not aligned with physical sex characteristics. The study included here simply suggests there may be some brain differences in transgender individuals that pre-date treatment with gender-affirming sex hormones. You may wish to direct questions to the lead author of the study.

I'll be curious to review the article you sent--thank you. I'm not a neurobiologist, but this is certainly a complex and fascinating field of study.

Best wishes,

Steve Rosenthal

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
Pronouns: He, Him, His
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434

Director, Endocrine Society
Director, World Professional Association for Transgender Health
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@gmail.com>
Sent: Saturday, January 16, 2021 4:23 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Follow up - article request

Dear Dr Rosenthal,

Thank you very much for taking the time to speak with me on Tuesday. In our discussion, you mentioned a study suggesting that the brains of transgender people more closely resemble brains of their identified, rather than their assigned, gender. You gave the example - I'm paraphrasing - of the structural part of the brain that governs awareness of shapes in space and said that the research showed that that part of the brain in transgender men looked "male". You offered to share a link to that research, and I am writing to ask, please, if you would.

A follow up question: I'm not sure I understand why having a body part (other than a primary or secondary sex characteristic) that resembles those of the "opposite" sex, makes you that gender, rather than just "more like" that gender? In your example, is a teen girl with broader "male" shoulders or a deeper "male" voice (like a teen girl with a "male" brain), necessarily a boy? Or is the brain, for its role in sending messages to other parts of the body, unique when we think about body and gender?

I am sharing with you an article I read today in Cerebrum Winter 2021 called "His and Hers: Sex Differences in the Brain" by Catherine Woolley, a neurobiologist at Northwestern. There's also a podcast by the same author. She seems to be arguing

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that it is not the structural aspects of the brain popularly associated with cognition (like the spatial awareness example) that differentiate male and female brains. I'm curious how her work might shed light on research into the transgender brain.

Thanks again for your time. Stay well,
[redacted]

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[redacted]

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, May 18, 2022 9:08 PM
To: [redacted]@gmail.com>
Subject: Re: Seattle Study

Hi [redacted]

Thanks for your emails--I apologize for the delay--just a very busy time.

I completely agree with you about the Tordoff et al. paper, and wish that I had realized the significant methodological concerns that were so well described by Jesse Singal before making reference to the article in our OpEd. Fortunately, there are a number of other recently published papers with sound methodology that demonstrate the positive mental health benefit of gender-affirming medical care. I have attached a recent review that I published in *Nature Reviews Endocrinology* that provides an overview of the field. We are still actively involved in our 4-site NIH study and now publishing articles on the impact of the first two years of gender-affirming care. I'm happy to share an article that's currently under review once it's in press. I couldn't agree more for the need for long-term follow-up, and that is exactly what we are committed to do.

Best wishes,

Steve Rosenthal

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
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Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From [redacted]@gmail.com>
Sent: Thursday, May 12, 2022 3:22 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Seattle Study

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Dear Dr Rosenthal,

I hope this finds you well. I read with interest your and Dr Ehrensaft's March article in the Chronicle. There, you cite the Diana Tordoff study from Seattle Children's Hospital as evidence of the "clear mental health benefits" of gender-affirming care. Except that, apparently, that study says no such thing. Jesse Singal's unpacking of the study is also discussedhere.

It breaks my heart (and, at one point, you told me that it kept you up at night - maybe no longer?) that the same shoddy research is wheeled out again and again. That does nothing for kids like mine. And for you and Dr Ehrensaft to wield shoddy research against politicians wielding their own baseless arguments seems sloppy at best, in bad faith at worst. When are we going to offer these kids, and their families, the complex, nuanced care they deserve?

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Best
[redacted]

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Obtained via CPRA by Judicial Watch, Inc.

[redacted]

[redacted]

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, August 3, 2022 4:56 PM
To: [redacted]@gmail.com>; [redacted] <dehrensaft@earthlink.net>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: Letter from Genspect

[redacted]

We are certainly aware of the recent Tavistock closure. We are continuing to follow our model of care in which no one at the CAGC receives any gender-affirming medical care without a thorough assessment by a qualified mental health gender specialist and then an evaluation process by our interdisciplinary team. Given my major work commitments, I am focusing efforts on our academic process of research data analysis and publication. I'm hopeful that in the very near future there will be an important paper published from our 4-site NIH study. I have cc'd our Public Information Officer, [redacted].

Thank you,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
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Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@gmail.com>
Sent: Wednesday, August 3, 2022 4:17 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <dehrensaft@earthlink.net>
Subject: Letter from Genspect

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This message came from outside your organization.

Dear Dr Rosenthal and Dr [redacted],

I trust that you have already received the attached letter from Genspect, following the closure of the Tavistock, but I am forwarding it here in case you have not. I've included the text of the letter below. I wonder if you would consider beginning a dialogue with an organization like Genspect in order to address publicly the concerns and questions they raise in the letter.

Thank you and regards
[redacted]

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From: [redacted]@ucsf.edu>
Sent: Friday, December 30, 2022 12:33 PM PST
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
CC: [redacted] <[redacted]@ucsf.edu>
Subject: Re: CAGC Consent Forms

Confirmed- uniform consent forms are in use.

[redacted]

[redacted], **NP**
Pediatric Nurse Practitioner
Endocrinology

UCSF Benioff Children's Hospital Oakland
744 52nd Street | Oakland, CA 94609
tel: 510-428-3654 | fax: 510-450-5614
[redacted]@ucsf.edu
www.childrenshospitaloakland.org
Facebook:ChildrensHospitalOakland
Twitter:UCSFBenioffOAK

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, December 27, 2022 9:53 AM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: [redacted] <[redacted]@ucsf.edu>
Subject: CAGC Consent Forms

Hi [redacted]
Please email me a copy of all CAGC consent forms (blocker, estradiol, testosterone, "anti-androgen").

Hi [redacted]
It's my understanding that we recently made our CAGC medical intervention consent forms uniform across both BCH-SF and BCH-Oak. Can you confirm, and if the consent forms at BCH-Oak are different from those at BCH-SF, please send them to me.

Thank you both,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
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Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

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From: [redacted]@feelgoodfunctionalmed.com>
Sent: Saturday, April 15, 2023 2:44 PM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Transgender Residency

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You have not previously corresponded with this sender.

Dear Dr. Deutsch,
My name is [redacted]. I am a family physician and a functional medicine physician in Bellingham Washington.

We do not have anyone in our town that provides trans care, and I am feeling called to try and meet that important need. I wonder if you accept practicing physicians for your month long rotation?

If not, could you please give me some direction in terms of the best course or online training that I could take to become up to date with the latest best standards of care for trans patients?

Warmly,
[redacted]

[redacted]
Feel Good Functional Medicine
Website: https://www.feelgoodfunctionalmed.com
YouTube: Feel Good Functional Medicine
Facebook: https://www.facebook.com/feelgoodfunctionalmedicine

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POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents

Jason Rafferty, MD, MPH, EdM, FAAP, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, COMMITTEE ON ADOLESCENCE, SECTION ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH AND WELLNESS

abstract

FREE

As a traditionally underserved population that faces numerous health disparities, youth who identify as transgender and gender diverse (TGD) and their families are increasingly presenting to pediatric providers for education, care, and referrals. The need for more formal training, standardized treatment, and research on safety and medical outcomes often leaves providers feeling ill equipped to support and care for patients that identify as TGD and families. In this policy statement, we review relevant concepts and challenges and provide suggestions for pediatric providers that are focused on promoting the health and positive development of youth that identify as TGD while eliminating discrimination and stigma.

INTRODUCTION

In its dedication to the health of all children, the American Academy of Pediatrics (AAP) strives to improve health care access and eliminate disparities for children and teenagers who identify as lesbian, gay, bisexual, transgender, or questioning (LGBTQ) of their sexual or gender identity.[1,2] Despite some advances in public awareness and legal protections, youth who identify as LGBTQ continue to face disparities that stem from multiple sources, including inequitable laws and policies, societal discrimination, and a lack of access to quality health care, including mental health care. Such challenges are often more intense for youth who do not conform to social expectations and norms regarding gender. Pediatric providers are increasingly encountering such youth and their families, who seek medical advice and interventions, yet they may lack the formal training to care for youth that identify as transgender and gender diverse (TGD) and their families.[3]

This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population, providing brief, relevant background on the basis of current available research

Department of Pediatrics, Hasbro Children's Hospital, Providence, Rhode Island; Thundermist Health Centers, Providence, Rhode Island; and Department of Child Psychiatry, Emma Pendleton Bradley Hospital, East Providence, Rhode Island

Dr Rafferty conceptualized the statement, drafted the initial manuscript, reviewed and revised the manuscript, approved the final manuscript as submitted, and agrees to be accountable for all aspects of the work.

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TABLE 1 Relevant Terms and Definitions Related to Gender Care

Term	Definition
Sex	An assignment that is made at birth, usually male or female, typically on the basis of external genital anatomy but sometimes on the basis of internal gonads, chromosomes, or hormone levels
Gender identity	A person's deep internal sense of being female, male, a combination of both, somewhere in between, or neither, resulting from a multifaceted interaction of biological traits, environmental factors, self-understanding, and cultural expectations
Gender expression	The external way a person expresses their gender, such as with clothing, hair, mannerisms, activities, or social roles
Gender perception	The way others interpret a person's gender expression
Gender diverse	A term that is used to describe people with gender behaviors, appearances, or identities that are incongruent with those culturally assigned to their birth sex; gender-diverse individuals may refer to themselves with many different terms, such as transgender, nonbinary, genderqueer,[7] gender fluid, gender creative, gender independent, or noncisgender. "Gender diverse" is used to acknowledge and include the vast diversity of gender identities that exists. It replaces the former term, "gender nonconforming," which has a negative and exclusionary connotation.
Transgender	A subset of gender-diverse youth whose gender identity does not match their assigned sex and generally remains persistent, consistent, and insistent over time; the term "transgender" also encompasses many other labels individuals may use to refer to themselves.
Cisgender	A term that is used to describe a person who identifies and expresses a gender that is consistent with the culturally defined norms of the sex they were assigned at birth
Agender	A term that is used to describe a person who does not identify as having a particular gender
Affirmed gender	When a person's true gender identity, or concern about their gender identity, is communicated to and validated from others as authentic
MTF; affirmed female; trans female	Terms that are used to describe individuals who were assigned male sex at birth but who have a gender identity and/or expression that is asserted to be more feminine
FTM; affirmed male; trans male	Terms that are used to describe individuals who were assigned female sex at birth but who have a gender identity and/or expression that is asserted to be more masculine
Gender dysphoria	A clinical symptom that is characterized by a sense of alienation to some or all of the physical characteristics or social roles of one's assigned gender; also, gender dysphoria is the psychiatric diagnosis in the *DSM-5*, which has focus on the distress that stems from the incongruence between one's expressed or experienced (affirmed) gender and the gender assigned at birth.
Gender identity disorder	A psychiatric diagnosis defined previously in the *DSM-IV* (changed to "gender dysphoria" in the *DSM-5*); the primary criteria include a strong, persistent cross-sex identification and significant distress and social impairment. This diagnosis is no longer appropriate for use and may lead to stigma, but the term may be found in older research.
Sexual orientation	A person's sexual identity in relation to the gender(s) to which they are attracted; sexual orientation and gender identity develop separately.

This list is not intended to be all inclusive. The pronouns "they" and "their" are used intentionally to be inclusive rather than the binary pronouns "he" and "she" and "his" and "her." Adapted from Bonifacio HJ, Rosenthal SM. Gender variance and dysphoria in children and adolescents. *Pediatr Clin North Am*. 2015;62(4):1001–1016. Adapted from Vance SR Jr, Ehrensaft D, Rosenthal SM. Psychological and medical care of gender nonconforming youth. *Pediatrics*. 2014;134(6):1184–1192. DSM-5, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*; DSM-IV, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*; FTM, female to male; MTF, male to female.

and expert opinion from clinical and research leaders, which will serve as the basis for recommendations. It is not a comprehensive review of clinical approaches and nuances to pediatric care for children and youth that identify as TGD. Professional understanding of youth that identify as TGD is a rapidly evolving clinical field in which research on appropriate clinical management is limited by insufficient funding.[3,4]

DEFINITIONS

To clarify recommendations and discussions in this policy statement, some definitions are provided. However, brief descriptions of human behavior or identities may not capture nuance in this evolving field. "Sex," or "natal gender," is a label, generally "male" or "female," that is typically assigned at birth on the basis of genetic and anatomic characteristics, such as genital anatomy, chromosomes, and sex hormone levels. Meanwhile, "gender identity" is one's internal sense of who one is, which results from a multifaceted interaction of biological traits, developmental influences, and environmental conditions. It may be male, female, somewhere in between, a combination of both, or neither (ie, not conforming to a binary conceptualization of gender). Self-recognition of gender identity develops over time, much the same way as a child's physical body does. For some people, gender identity can be fluid, shifting in different contexts. "Gender expression" refers to the wide array of ways people display their gender through clothing, hair styles, mannerisms, or social roles. Exploring different ways of expressing gender is common for children and may challenge social expectations. The way others interpret this expression is referred to as "gender perception" (Table 1).[5,6]

These labels may or may not be congruent. The term "cisgender" is used if someone identifies and expresses a gender that is consistent with the culturally defined norms of the sex that was assigned at birth. "Gender diverse" is an umbrella term to describe an ever-evolving array of labels that people may apply when their gender identity, expression, or even perception does not conform

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to the norms and stereotypes others expect of their assigned sex. "Transgender" is usually reserved for a subset of such youth whose gender identity does not match their assigned sex and generally remains persistent, consistent, and insistent over time. These terms are not diagnoses; rather, they are personal and often dynamic ways of describing one's own gender experience.

Gender identity is not synonymous with "sexual orientation," which refers to a person's identity in relation to the gender(s) to which they are sexually and romantically attracted. Gender identity and sexual orientation are distinct but interrelated constructs.[8] Therefore, being transgender does not imply a sexual orientation, and people who identify as transgender still identify as straight, gay, bisexual, etc, on the basis of their attractions. (For more information, *The Gender Book*, found at www.thegenderbook.com, is a resource with illustrations that are used to highlight these core terms and concepts.)

EPIDEMIOLOGY

In population-based surveys, questions related to gender identity are rarely asked, which makes it difficult to assess the size and characteristics of the population that is TGD. In the 2014 Behavioral Risk Factor Surveillance System of the Centers for Disease Control and Prevention, only 19 states elected to include optional questions on gender identity. Extrapolation from these data suggests that the US prevalence of adults who identify as transgender or "gender nonconforming" is 0.6% (1.4 million), ranging from 0.3% in North Dakota to 0.8% in Hawaii.[9] On the basis of these data, it has been estimated that 0.7% of youth ages 13 to 17 years (~150 000) identify as transgender.[10] This number is much higher than previous estimates, which were extrapolated from individual states or specialty clinics, and is likely an underestimate given the stigma regarding those who openly identify as transgender and the difficulty in defining "transgender" in a way that is inclusive of all gender-diverse identities.[11]

There have been no large-scale prevalence studies among children and adolescents, and there is no evidence that adult statistics reflect young children or adolescents. In the 2014 Behavioral Risk Factor Surveillance System, those 18 to 24 years of age were more likely than older age groups to identify as transgender (0.7%).[9] Children report being aware of gender incongruence at young ages. Children who later identify as TGD report first having recognized their gender as "different" at an average age of 8.5 years; however, they did not disclose such feelings until an average of 10 years later.[12]

MENTAL HEALTH IMPLICATIONS

Adolescents and adults who identify as transgender have high rates of depression, anxiety, eating disorders, self-harm, and suicide.[13–20] Evidence suggests that an identity of TGD has an increased prevalence among individuals with autism spectrum disorder, but this association is not yet well understood.[21,22] In 1 retrospective cohort study, 56% of youth who identified as transgender reported previous suicidal ideation, and 31% reported a previous suicide attempt, compared with 20% and 11% among matched youth who identified as cisgender, respectively.[13] Some youth who identify as TGD also experience gender dysphoria, which is a specific diagnosis given to those who experience impairment in peer and/or family relationships, school performance, or other aspects of their life as a consequence of the incongruence between their assigned sex and their gender identity.[23]

There is no evidence that risk for mental illness is inherently attributable to one's identity of TGD. Rather, it is believed to be multifactorial, stemming from an internal conflict between one's appearance and identity, limited availability of mental health services, low access to health care providers with expertise in caring for youth who identify as TGD, discrimination, stigma, and social rejection.[24] This was affirmed by the American Psychological Association in 2008[25] (with practice guidelines released in 2015[8]) and the American Psychiatric Association, which made the following statement in 2012:

> *Being transgender or gender variant implies no impairment in judgment, stability, reliability, or general social or vocational capabilities; however, these individuals often experience discrimination due to a lack of civil rights protections for their gender identity or expression.… [Such] discrimination and lack of equal civil rights is damaging to the mental health of transgender and gender variant individuals.*[26]

Youth who identify as TGD often confront stigma and discrimination, which contribute to feelings of rejection and isolation that can adversely affect physical and emotional well-being. For example, many youth believe that they must hide their gender identity and expression to avoid bullying, harassment, or victimization. Youth who identify as TGD experience disproportionately high rates of homelessness, physical violence (at home and in the community), substance abuse, and high-risk sexual behaviors.[5,6,12,27–31] Among the 3 million HIV testing events that were reported in 2015, the highest percentages of new infections were among women who identified as transgender[32] and were also at particular risk for not knowing their HIV status.[30]

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GENDER-AFFIRMATIVE CARE

In a gender-affirmative care model (GACM), pediatric providers offer developmentally appropriate care that is oriented toward understanding and appreciating the youth's gender experience. A strong, nonjudgmental partnership with youth and their families can facilitate exploration of complicated emotions and gender-diverse expressions while allowing questions and concerns to be raised in a supportive environment.[5] In a GACM, the following messages are conveyed:

- transgender identities and diverse gender expressions do not constitute a mental disorder;
- variations in gender identity and expression are normal aspects of human diversity, and binary definitions of gender do not always reflect emerging gender identities;
- gender identity evolves as an interplay of biology, development, socialization, and culture; and
- if a mental health issue exists, it most often stems from stigma and negative experiences rather than being intrinsic to the child.[27,33]

The GACM is best facilitated through the integration of medical, mental health, and social services, including specific resources and supports for parents and families.[24] Providers work together to destigmatize gender variance, promote the child's self-worth, facilitate access to care, educate families, and advocate for safer community spaces where children are free to develop and explore their gender.[5] A specialized gender-affirmative therapist, when available, may be an asset in helping children and their families build skills for dealing with gender-based stigma, address symptoms of anxiety or depression, and reinforce the child's overall resiliency.[34,35] There is a limited but growing body of evidence that suggests that using an integrated affirmative model results in young people having fewer mental health concerns whether they ultimately identify as transgender.[24,36,37]

In contrast, "conversion" or "reparative" treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions. The Substance Abuse and Mental Health Services Administration has concluded that any therapeutic intervention with the goal of changing a youth's gender expression or identity is inappropriate.[33] Reparative approaches have been proven to be not only unsuccessful[38] but also deleterious and are considered outside the mainstream of traditional medical practice.[29,39–42] The AAP described reparative approaches as "unfair and deceptive."[43] At the time of this writing,* conversion therapy was banned by executive regulation in New York and by legislative statutes in 9 other states as well as the District of Columbia.[44]

Pediatric providers have an essential role in assessing gender concerns and providing evidence-based information to assist youth and families in medical decision-making. Not doing so can prolong or exacerbate gender dysphoria and contribute to abuse and stigmatization.[35] If a pediatric provider does not feel prepared to address gender concerns when they occur, then referral to a pediatric or mental health provider with more expertise is appropriate. There is little research on communication and efficacy with transfers in care for youth who identify as TGD, particularly from pediatric to adult providers.

DEVELOPMENTAL CONSIDERATIONS

Acknowledging that the capacity for emerging abstract thinking in childhood is important to conceptualize and reflect on identity, gender-affirmation guidelines are being focused on individually tailored interventions on the basis of the physical and cognitive development of youth who identify as TGD.[45] Accordingly, research substantiates that children who are prepubertal and assert an identity of TGD know their gender as clearly and as consistently as their developmentally equivalent peers who identify as cisgender and benefit from the same level of social acceptance.[46] This developmental approach to gender affirmation is in contrast to the outdated approach in which a child's gender-diverse assertions are held as "possibly true" until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed "watchful waiting." This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment ("desisters").[45,47] More robust and current research suggests that, rather than focusing on who a child will become, valuing them for who they are, even at a young age, fosters secure attachment and resilience, not only for the child but also for the whole family.[5,45,48,49]

* For more information regarding state-specific laws, please contact the AAP Division of State Government Affairs at stgov@ aap.org.

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MEDICAL MANAGEMENT

Pediatric primary care providers are in a unique position to routinely inquire about gender development in children and adolescents as part of recommended well-child visits[50] and to be a reliable source of validation, support, and reassurance. They are often the first provider to be aware that a child may not identify as cisgender or that there may be distress related to a gender-diverse identity. The best way to approach gender with patients is to inquire directly and nonjudgmentally about their experience and feelings before applying any labels.[27,51]

Many medical interventions can be offered to youth who identify as TGD and their families. The decision of whether and when to initiate gender-affirmative treatment is personal and involves careful consideration of risks, benefits, and other factors unique to each patient and family. Many protocols suggest that clinical assessment of youth who identify as TGD is ideally conducted on an ongoing basis in the setting of a collaborative, multidisciplinary approach, which, in addition to the patient and family, may include the pediatric provider, a mental health provider (preferably with expertise in caring for youth who identify as TGD), social and legal supports, and a pediatric endocrinologist or adolescent-medicine gender specialist, if available.[6,28] There is no prescribed path, sequence, or end point. Providers can make every effort to be aware of the influence of their own biases. The medical options also vary depending on pubertal and developmental progression.

Clinical Setting

In the past year, 1 in 4 adults who identified as transgender avoided a necessary doctor's visit because of fear of being mistreated.[31] All clinical office staff have a role in affirming a patient's gender identity. Making flyers available or displaying posters related to LGBTQ health issues, including information for children who identify as TGD and families, reveals inclusivity and awareness. Generally, patients who identify as TGD feel most comfortable when they have access to a gender-neutral restroom. Diversity training that encompasses sensitivity when caring for youth who identify as TGD and their families can be helpful in educating clinical and administrative staff. A patient-asserted name and pronouns are used by staff and are ideally reflected in the electronic medical record without creating duplicate charts.[52,53] The US Centers for Medicare and Medicaid Services and the National Coordinator for Health Information Technology require all electronic health record systems certified under the Meaningful Use incentive program to have the capacity to confidentially collect information on gender identity.[54,55] Explaining and maintaining confidentiality procedures promotes openness and trust, particularly with youth who identify as LGBTQ.[1] Maintaining a safe clinical space can provide at least 1 consistent, protective refuge for patients and families, allowing authentic gender expression and exploration that builds resiliency.

Pubertal Suppression

Gonadotrophin-releasing hormones have been used to delay puberty since the 1980s for central precocious puberty.[56] These reversible treatments can also be used in adolescents who experience gender dysphoria to prevent development of secondary sex characteristics and provide time up until 16 years of age for the individual and the family to explore gender identity, access psychosocial supports, develop coping skills, and further define appropriate treatment goals. If pubertal suppression treatment is suspended, then endogenous puberty will resume.[20,57,58]

Often, pubertal suppression creates an opportunity to reduce distress that may occur with the development of secondary sexual characteristics and allow for gender-affirming care, including mental health support for the adolescent and the family. It reduces the need for later surgery because physical changes that are otherwise irreversible (protrusion of the Adam's apple, male pattern baldness, voice change, breast growth, etc) are prevented. The available data reveal that pubertal suppression in children who identify as TGD generally leads to improved psychological functioning in adolescence and young adulthood.[20,57–59]

Pubertal suppression is not without risks. Delaying puberty beyond one's peers can also be stressful and can lead to lower self-esteem and increased risk taking.[60] Some experts believe that genital underdevelopment may limit some potential reconstructive options.[61] Research on long-term risks, particularly in terms of bone metabolism[62] and fertility,[63] is currently limited and provides varied results.[57,64,65] Families often look to pediatric providers for help in considering whether pubertal suppression is indicated in the context of their child's overall well-being as gender diverse.

Gender Affirmation

As youth who identify as TGD reflect on and evaluate their gender identity, various interventions may be considered to better align their gender expression with their underlying identity. This process of reflection, acceptance, and, for some, intervention is known as "gender affirmation." It was formerly referred to as "transitioning," but many view the process as an affirmation and acceptance of who they have always been rather than a transition

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TABLE 2 The Process of Gender Affirmation May Include ≥1 of the Following Components

Component	Definition	General Age Range[a]	Reversibility[a]
Social affirmation	Adopting gender-affirming hairstyles, clothing, name, gender pronouns, and restrooms and other facilities	Any	Reversible
Puberty blockers	Gonadotropin-releasing hormone analogues, such as leuprolide and histrelin	During puberty (Tanner stage 2–5)[b]	Reversible[c]
Cross-sex hormone therapy	Testosterone (for those who were assigned female at birth and are masculinizing); estrogen plus androgen inhibitor (for those who were assigned male at birth and are feminizing)	Early adolescence onward	Partially reversible (skin texture, muscle mass, and fat deposition); irreversible once developed (testosterone: Adam's apple protrusion, voice changes, and male pattern baldness; estrogen: breast development); unknown reversibility (effect on fertility)
Gender-affirming surgeries	"Top" surgery (to create a male-typical chest shape or enhance breasts); "bottom" surgery (surgery on genitals or reproductive organs); facial feminization and other procedures	Typically adults (adolescents on case-by-case basis[d])	Not reversible
Legal affirmation	Changing gender and name recorded on birth certificate, school records, and other documents	Any	Reversible

[a] Note that the provided age range and reversibility is based on the little data that are currently available.
[b] There is limited benefit to starting gonadotropin-releasing hormone after Tanner stage 5 for pubertal suppression. However, when cross-sex hormones are initiated with a gradually increasing schedule, the initial levels are often not high enough to suppress endogenous sex hormone secretion. Therefore, gonadotropin-releasing hormone may be continued in accordance with the Endocrine Society Guidelines.[68]
[c] The effect of sustained puberty suppression on fertility is unknown. Pubertal suppression can be, and often is indicated to be, followed by cross-sex hormone treatment. However, when cross-sex hormones are initiated without endogenous hormones, then fertility may be decreased.[68]
[d] Eligibility criteria for gender-affirmative surgical interventions among adolescents are not clearly defined between established protocols and practice. When applicable, eligibility is usually determined on a case-by-case basis with the adolescent and the family along with input from medical, mental health, and surgical providers.[68–71]

from 1 gender identity to another. Accordingly, some people who have gone through the process prefer to call themselves "affirmed females, males, etc" (or just "females, males, etc"), rather than using the prefix "trans-." Gender affirmation is also used to acknowledge that some individuals who identify as TGD may feel affirmed in their gender without pursuing medical or surgical interventions.[7,66]

Supportive involvement of parents and family is associated with better mental and physical health outcomes.[67] Gender affirmation among adolescents with gender dysphoria often reduces the emphasis on gender in their lives, allowing them to attend to other developmental tasks, such as academic success, relationship building, and future-oriented planning.[64] Most protocols for gender-affirming interventions incorporate World Professional Association of Transgender Health[35] and Endocrine Society[68] recommendations and include ≥1 of the following elements (Table 2):

1. Social Affirmation: This is a reversible intervention in which children and adolescents express partially or completely in their asserted gender identity by adapting hairstyle, clothing, pronouns, name, etc. Children who identify as transgender and socially affirm and are supported in their asserted gender show no increase in depression and only minimal (clinically insignificant) increases in anxiety compared with age-matched averages.[48] Social affirmation can be complicated given the wide range of social interactions children have (eg, extended families, peers, school, community, etc). There is little guidance on the best approach (eg, all at once, gradual, creating new social networks, or affirming within existing networks, etc). Pediatric providers can best support families by anticipating and discussing such complexity proactively, either in their own practice or through enlisting a qualified mental health provider.

2. Legal Affirmation: Elements of a social affirmation, such as a name and gender marker, become official on legal documents, such as birth certificates, passports, identification cards, school documents, etc. The processes for making these changes depend on state laws and may require specific documentation from pediatric providers.

3. Medical Affirmation: This is the process of using cross-sex hormones to allow adolescents who have initiated puberty to develop secondary sex characteristics of the opposite biological sex. Some changes are partially reversible if hormones are stopped, but others become

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irreversible once they are fully developed (Table 2).

4. Surgical Affirmation: Surgical approaches may be used to feminize or masculinize features, such as hair distribution, chest, or genitalia, and may include removal of internal organs, such as ovaries or the uterus (affecting fertility). These changes are irreversible. Although current protocols typically reserve surgical interventions for adults,[35,68] they are occasionally pursued during adolescence on a case-by-case basis, considering the necessity and benefit to the adolescent's overall health and often including multidisciplinary input from medical, mental health, and surgical providers as well as from the adolescent and family.[69–71]

For some youth who identify as TGD whose natal gender is female, menstruation, breakthrough bleeding, and dysmenorrhea can lead to significant distress before or during gender affirmation. The American College of Obstetrics and Gynecology suggests that, although limited data are available to outline management, menstruation can be managed without exogenous estrogens by using a progesterone-only pill, a medroxyprogesterone acetate shot, or a progesterone-containing intrauterine or implantable device.[72] If estrogen can be tolerated, oral contraceptives that contain both progesterone and estrogen are more effective at suppressing menses.[73] The Endocrine Society guidelines also suggest that gonadotrophin-releasing hormones can be used for menstrual suppression before the anticipated initiation of testosterone or in combination with testosterone for breakthrough bleeding (enables phenotypic masculinization at a lower dose than if testosterone is used alone).[68] Masculinizing hormones in natal female patients may lead to a cessation of menses, but unplanned pregnancies have been reported, which emphasizes the need for ongoing contraceptive counseling with youth who identify as TGD.[72]

HEALTH DISPARITIES

In addition to societal challenges, youth who identify as TGD face several barriers within the health care system, especially regarding access to care. In 2015, a focus group of youth who identified as transgender in Seattle, Washington, revealed 4 problematic areas related to health care:

1. safety issues, including the lack of safe clinical environments and fear of discrimination by providers;
2. poor access to physical health services, including testing for sexually transmitted infections;
3. inadequate resources to address mental health concerns; and
4. lack of continuity with providers.[74]

This study reveals the obstacles many youth who identify as TGD face in accessing essential services, including the limited supply of appropriately trained medical and psychological providers, fertility options, and insurance coverage denials for gender-related treatments.[74]

Insurance denials for services related to the care of patients who identify as TGD are a significant barrier. Although the Office for Civil Rights of the US Department of Health and Human Services explicitly stated in 2012 that the nondiscrimination provision in the Patient Protection and Affordable Care Act includes people who identify as gender diverse,[75,76] insurance claims for gender affirmation, particularly among youth who identify as TGD, are frequently denied.[54,77] In 1 study, it was found that approximately 25% of individuals who identified as transgender were denied insurance coverage because of being transgender.[31] The burden of covering medical expenses that are not covered by insurance can be financially devastating, and even when expenses are covered, families describe high levels of stress in navigating and submitting claims appropriately.[78] In 2012, a large gender center in Boston, Massachusetts, reported that most young patients who identified as transgender and were deemed appropriate candidates for recommended gender care were unable to obtain it because of such denials, which were based on the premise that gender dysphoria was a mental disorder, not a physical one, and that treatment was not medically or surgically necessary.[24] This practice not only contributes to stigma, prolonged gender dysphoria, and poor mental health outcomes,[77] but it may also lead patients to seek nonmedically supervised treatments that are potentially dangerous.[24] Furthermore, insurance denials can reinforce a socioeconomic divide between those who can finance the high costs of uncovered care and those who cannot.[24,77]

The transgender youth group in Seattle likely reflected the larger TGD population when they described how obstacles adversely affect self-esteem and contribute to the perception that they are undervalued by society and the health care system.[74,77] Professional medical associations, including the AAP, are increasingly calling for equity in health care provisions regardless of gender identity or expression.[1,8,23,72] There is a critical need for investments in research on the prevalence, disparities, biological underpinnings, and standards of care relating to gender-diverse populations. Pediatric providers who work with state government and insurance officials can play an essential role in advocating for

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stronger nondiscrimination policies and improved coverage.

There is a lack of quality research on the experience of youth of color who identify as transgender. One theory suggests that the intersection of racism, transphobia, and sexism may result in the extreme marginalization that is experienced among many women of color who identify as transgender,[79] including rejection from their family and dropping out of school at younger ages (often in the setting of rigid religious beliefs regarding gender),[80] increased levels of violence and body objectification,[81] 3 times the risk of poverty compared with the general population,[31] and the highest prevalence of HIV compared with other risk groups (estimated as high as 56.3% in 1 meta-analysis).[30] One model suggests that pervasive stigma and oppression can be associated with psychological distress (anxiety, depression, and suicide) and adoption of risk behaviors by such youth to obtain a sense of validation toward their complex identities.[79]

FAMILY ACCEPTANCE

Research increasingly suggests that familial acceptance or rejection ultimately has little influence on the gender identity of youth; however, it may profoundly affect young people's ability to openly discuss or disclose concerns about their identity. Suppressing such concerns can affect mental health.[82] Families often find it hard to understand and accept their child's gender-diverse traits because of personal beliefs, social pressure, and stigma.[49,83] Legitimate fears may exist for their child's welfare, safety, and acceptance that pediatric providers need to appreciate and address. Families can be encouraged to communicate their concerns and questions. Unacknowledged concerns can contribute to shame and hesitation in regard to offering support and understanding,[84] which is essential for the child's self-esteem, social involvement, and overall health as TGD.[48,85–87] Some caution has been expressed that unquestioning acceptance per se may not best serve questioning youth or their families. Instead, psychological evidence suggests that the most benefit comes when family members and youth are supported and encouraged to engage in reflective perspective taking and validate their own and the other's thoughts and feelings despite divergent views.[49,82]

In this regard, suicide attempt rates among 433 adolescents in Ontario who identified as "trans" were 4% among those with strongly supportive parents and as high as 60% among those whose parents were not supportive.[85] Adolescents who identify as transgender and endorse at least 1 supportive person in their life report significantly less distress than those who only experience rejection. In communities with high levels of support, it was found that nonsupportive families tended to increase their support over time, leading to dramatic improvement in mental health outcomes among their children who identified as transgender.[88]

Pediatric providers can create a safe environment for parents and families to better understand and listen to the needs of their children while receiving reassurance and education.[83] It is often appropriate to assist the child in understanding the parents' concerns as well. Despite expectations by some youth with transgender identity for immediate acceptance after "coming out," family members often proceed through a process of becoming more comfortable and understanding of the youth's gender identity, thoughts, and feelings. One model suggests that the process resembles grieving, wherein the family separates from their expectations for their child to embrace a new reality. This process may proceed through stages of shock, denial, anger, feelings of betrayal, fear, self-discovery, and pride.[89] The amount of time spent in any of these stages and the overall pace varies widely. Many family members also struggle as they are pushed to reflect on their own gender experience and assumptions throughout this process. In some situations, youth who identify as TGD may be at risk for internalizing the difficult emotions that family members may be experiencing. In these cases, individual and group therapy for the family members may be helpful.[49,78]

Family dynamics can be complex, involving disagreement among legal guardians or between guardians and their children, which may affect the ability to obtain consent for any medical management or interventions. Even in states where minors may access care without parental consent for mental health services, contraception, and sexually transmitted infections, parental or guardian consent is required for hormonal and surgical care of patients who identify as TGD.[72,90] Some families may take issue with providers who address gender concerns or offer gender-affirming care. In rare cases, a family may deny access to care that raises concerns about the youth's welfare and safety; in those cases, additional legal or ethical support may be useful to consider. In such rare situations, pediatric providers may want to familiarize themselves with relevant local consent laws and maintain their primary responsibility for the welfare of the child.

SAFE SCHOOLS AND COMMUNITIES

Youth who identify as TGD are becoming more visible because gender-diverse expression is increasingly admissible in the media, on social media, and in schools and communities. Regardless of whether a youth with a gender-diverse

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identity ultimately identifies as transgender, challenges exist in nearly every social context, from lack of understanding to outright rejection, isolation, discrimination, and victimization. In the US Transgender Survey of nearly 28 000 respondents, it was found that among those who were out as or perceived to be TGD between kindergarten and eighth grade, 54% were verbally harassed, 24% were physically assaulted, and 13% were sexually assaulted; 17% left school because of maltreatment.[31] Education and advocacy from the medical community on the importance of safe schools for youth who identify as TGD can have a significant effect.

At the time of this writing,* only 18 states and the District of Columbia had laws that prohibited discrimination based on gender expression when it comes to employment, housing, public accommodations, and insurance benefits. Over 200 US cities have such legislation. In addition to basic protections, many youth who identify as TGD also have to navigate legal obstacles when it comes to legally changing their name and/or gender marker.[54] In addition to advocating and working with policy makers to promote equal protections for youth who identify as TGD, pediatric providers can play an important role by developing a familiarity with local laws and organizations that provide social work and legal assistance to youth who identify as TGD and their families.

School environments play a significant role in the social and emotional development of children. Every child has a right to feel safe and respected at school, but for youth who identify as TGD, this can be challenging. Nearly every aspect of school life may present safety concerns and require negotiations regarding their gender expression, including name/pronoun use, use of bathrooms and locker rooms, sports teams, dances and activities, overnight activities, and even peer groups. Conflicts in any of these areas can quickly escalate beyond the school's control to larger debates among the community and even on a national stage.

The formerly known Gay, Lesbian, and Straight Education Network (GLSEN), an advocacy organization for youth who identify as LGBTQ, conducts an annual national survey to measure LGBTQ well-being in US schools. In 2015, students who identified as LGBTQ reported high rates of being discouraged from participation in extracurricular activities. One in 5 students who identified as LGBTQ reported being hindered from forming or participating in a club to support lesbian, gay, bisexual, or transgender students (eg, a gay straight alliance, now often referred to as a genders and sexualities alliance) despite such clubs at schools being associated with decreased reports of negative remarks about sexual orientation or gender expression, increased feelings of safety and connectedness at school, and lower levels of victimization. In addition, >20% of students who identified as LGBTQ reported being blocked from writing about LGBTQ issues in school yearbooks or school newspapers or being prevented or discouraged by coaches and school staff from participating in sports because of their sexual orientation or gender expression.[91]

One strategy to prevent conflict is to proactively support policies and protections that promote inclusion and safety of all students. However, such policies are far from consistent across districts. In 2015, GLSEN found that 43% of children who identified as LGBTQ reported feeling unsafe at school because of their gender expression, but only 6% reported that their school had official policies to support youth who identified as TGD, and only 11% reported that their school's antibullying policies had specific protections for gender expression.[91] Consequently, more than half of the students who identified as transgender in the study were prevented from using the bathroom, names, or pronouns that aligned with their asserted gender at school. A lack of explicit policies that protected youth who identified as TGD was associated with increased reported victimization, with more than half of students who identified as LGBTQ reporting verbal harassment because of their gender expression. Educators and school administrators play an essential role in advocating for and enforcing such policies. GLSEN found that when students recognized actions to reduce gender-based harassment, both students who identified as transgender and cisgender reported a greater connection to staff and feelings of safety.[91] In another study, schools were open to education regarding gender diversity and were willing to implement policies when they were supported by external agencies, such as medical professionals.[92]

Academic content plays an important role in building a safe school environment as well. The 2015 GLSEN survey revealed that when positive representations of people who identified as LGBTQ were included in the curriculum, students who identified as LGBTQ reported less hostile school environments, less victimization and greater feelings of safety, fewer school absences because of feeling unsafe, greater feelings of connectedness to their school

* For more information regarding state-specific laws, please contact the AAP Division of State Government Affairs at stgov@ aap.org.

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community, and an increased interest in high school graduation and postsecondary education.[91] At the time of this writing,* 8 states had laws that explicitly forbade teachers from even discussing LGBTQ issues.[54]

MEDICAL EDUCATION

One of the most important ways to promote high-quality health care for youth who identify as TGD and their families is increasing the knowledge base and clinical experience of pediatric providers in providing culturally competent care to such populations, as recommended by the recently released guidelines by the Association of American Medical Colleges.[93] This begins with the medical school curriculum in areas such as human development, sexual health, endocrinology, pediatrics, and psychiatry. In a 2009–2010 survey of US medical schools, it was found that the median number of hours dedicated to LGBTQ health was 5, with one-third of US medical schools reporting no LGBTQ curriculum during the clinical years.[94]

During residency training, there is potential for gender diversity to be emphasized in core rotations, especially in pediatrics, psychiatry, family medicine, and obstetrics and gynecology. Awareness could be promoted through the inclusion of topics relevant to caring for children who identify as TGD in the list of core competencies published by the American Board of Pediatrics, certifying examinations, and relevant study materials. Continuing education and maintenance of certification activities can include topics relevant to TGD populations as well.

* For more information regarding state-specific laws, please contact the AAP Division of State Government Affairs at stgov@ aap.org.

RECOMMENDATIONS

The AAP works toward all children and adolescents, regardless of gender identity or expression, receiving care to promote optimal physical, mental, and social well-being. Any discrimination based on gender identity or expression, real or perceived, is damaging to the socioemotional health of children, families, and society. In particular, the AAP recommends the following:

1. that youth who identify as TGD have access to comprehensive, gender-affirming, and developmentally appropriate health care that is provided in a safe and inclusive clinical space;
2. that family-based therapy and support be available to recognize and respond to the emotional and mental health needs of parents, caregivers, and siblings of youth who identify as TGD;
3. that electronic health records, billing systems, patient-centered notification systems, and clinical research be designed to respect the asserted gender identity of each patient while maintaining confidentiality and avoiding duplicate charts;
4. that insurance plans offer coverage for health care that is specific to the needs of youth who identify as TGD, including coverage for medical, psychological, and, when indicated, surgical gender-affirming interventions;
5. that provider education, including medical school, residency, and continuing education, integrate core competencies on the emotional and physical health needs and best practices for the care of youth who identify as TGD and their families;
6. that pediatricians have a role in advocating for, educating, and developing liaison relationships with school districts and other community organizations to promote acceptance and inclusion of all children without fear of harassment, exclusion, or bullying because of gender expression;
7. that pediatricians have a role in advocating for policies and laws that protect youth who identify as TGD from discrimination and violence;
8. that the health care workforce protects diversity by offering equal employment opportunities and workplace protections, regardless of gender identity or expression; and
9. that the medical field and federal government prioritize research that is dedicated to improving the quality of evidence-based care for youth who identify as TGD.

LEAD AUTHOR

Jason Richard Rafferty, MD, MPH, EdM, FAAP

CONTRIBUTOR

Robert Garofalo, MD, FAAP

COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, 2017–2018

Michael Yogman, MD, FAAP, Chairperson
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LIAISONS

Sharon Berry, PhD, LP – *Society of Pediatric Psychology*
Ed Christophersen, PhD, FAAP – *Society of Pediatric Psychology*
Norah Johnson, PhD, RN, CPNP-BC – *National Association of Pediatric Nurse Practitioners*
Amy Starin, PhD, LCSW – *National Association of Social Workers*
Abigail Schlesinger, MD – *American Academy of Child and Adolescent Psychiatry*

STAFF

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James Baumberger

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Makia E. Powers, MD, MPH, FAAP
Krishna Upadhya, MD, FAAP
Stephenie B. Wallace, MD, FAAP

LIAISONS

Laurie Hornberger, MD, MPH, FAAP – *Section on Adolescent Health*
Liwei L. Hua, MD, PhD – *American Academy of Child and Adolescent Psychiatry*
Margo A. Lane, MD, FRCPC, FAAP – *Canadian Paediatric Society*
Meredith Loveless, MD, FACOG – *American College of Obstetricians and Gynecologists*
Seema Menon, MD – *North American Society of Pediatric and Adolescent Gynecology*
CDR Lauren B. Zapata, PhD, MSPH – *Centers for Disease Control and Prevention*

STAFF

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Ellen Perrin, MD, MA, FAAP

LIAISON

Joseph H. Waters, MD – *AAP Section on Pediatric Trainees*

STAFF

Renee Jarrett, MPH

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ABBREVIATIONS

AAP: American Academy of Pediatrics
GACM: gender-affirmative care model
GLSEN: Gay, Lesbian, and Straight Education Network
LGBTQ: lesbian, gay, bisexual, transgender, or questioning
TGD: transgender and gender diverse

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Address correspondence to Jason Rafferty, MD, MPH, EdM, FAAP. E-mail: Jason_Rafferty@mail.harvard.edu

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Subject: UCSF EM Residency Conference
Location: https://ucsf.zoom.us/[redacted]

Start: Thursday, April 20, 2023 8:00 AM PDT
End: Thursday, April 20, 2023 12:30 PM PDT
Show Time As: Tentative

Recurrence: None

Meeting Status: Not yet responded

Organizer: [redacted]
Optional Attendees: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>;

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<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@hs.uci.edu
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<[redacted]@ucsf.edu>; [redacted]@gmail.com <[redacted]@gmail.com>; [redacted]
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<[redacted]@sfgh.ucsf.edu>; [redacted]@ucsf.edu>;
[redacted]@ucsf.edu>; [redacted]@sfdph.org <[redacted]
[redacted]@sfdph.org>; Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@gmail.com
<[redacted]@gmail.com>; [redacted]@sfdph.org>; [redacted]@sfdph.org>;
[redacted]@ucsf.edu>; [redacted]@ucsf.edu>;
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[redacted]@ucsf.edu>; [redacted]@sfdph.org>; [redacted]
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; [redacted]@sfdph.org>; [redacted]
[redacted]@gmail.com>

Schedule:

Time	Session	Instructor(s)
8:00 – 8:30am	Chiefs' Conference	[redacted]
8:30 – 9:00am	Trauma: Penetrating Thoracic Trauma	
9:00 – 11:30am	SAEM/PAS Prep	
11:30am – 12:30pm	Trauma: Care of the Trauma Patient in Different Settings	

Obtained via CPRA by Judicial Watch, Inc.

Friday, May 5, 2023
Transgender Health Summit

Obtained via CPRA by Judicial Watch, Inc.

7:00am	***Continental Breakfast and Registration***	
	Concurrent Workshops	
8:00	**Introductory Medicine Track** - Terminology, Demographics, and Health Disparities - Building an Inclusive and Affirming Clinical Environment	[redacted]
	Next Level Medicine Track - Managing patients with co-occurring cardiovascular, Cerebrovascular, and thromboembolic disease or risks	Maddie Deutsch, MD, MPH
	Next Level Mental Health Track - Critical considerations in the assessment of pubertal-age youth	[redacted]
9:00	**Introductory Medicine Track** - Overview of gender affirming care and treatment - Introduction to hormone therapy	[redacted]
	Introductory Mental Health Track - Surgical assessment and preparation	[redacted]
	Next Level Medicine Track - Approach to trans and gender expansive youth and adolescents - Bone health across the lifespan	[redacted]
	Next Level Mental Health Track (sub-session A) - Approach to pre-pubertal children	[redacted]
	Next Level Mental Health Track (sub-session B) - Psychotherapeutic interventions for adults	[redacted]
10:15	*Break*	
	Concurrent Workshops	
10:35	**Introductory Medicine Track** - Approach to trans and gender expansive youth and adolescents - Bone health across the lifespan	[redacted]
	Introductory Mental Health Track - Assessment of adults - Psychotherapeutic interventions for adults	[redacted]
	Next Level Medicine Track - Gynecologic considerations for people with ovaries and/or a uterus	[redacted]
	Next Level Mental Health Track - In-depth surgical assessments and preparation	[redacted]
11:35	**Introductory Medicine Track** - Primary care	[redacted]
	Introductory Mental Health Track - Approach to pre-pubertal and pubertal children	[redacted]
	Next Level Medicine Track - Complex cases	Maddie Deutsch, MD, MPH
	Next Level Mental Health Track - Review of current literature	[redacted]
12:35pm	*Lunch*	
2:00	**SOC8 Updates**	[redacted]
2:30	**Voice and Communication**	[redacted]
3:00	**Fertility and Family Building**	[redacted]
4:00	*Break*	
	Concurrent Workshops	
4:15	**Medical Track** - Common surgical complications and management	[redacted]
	Mental Health Track - Managing patients with co-occurring mental health diagnoses - Neurodiversity	[redacted]
5:00	**Multidisciplinary Approaches to Trans and Gender Diverse Youth and Adolescent Care**	[redacted]
6:00pm	*Adjourn*	

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, April 26, 2023 3:26 PM PDT
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
CC: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]

I have cc'd Dr. Maddie Deutsch, Director of Adult Transgender Services, who should be able to answer your question.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 11:44 AM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: FW: Ped Endo (Gender) Montgomery

Hi Drs. [redacted] Rosenthal,

Can you clarify who will be scheduling patients for [redacted] at Montgomery location?
See [redacted]s response below in blue italic.

Once you confirm then I can proceed with submitting the request for Apex Govn team.

Thank you,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 11:04 AM
To: [redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]
See answers below.
Thanks,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 10:08 AM
To: [redacted]@ucsf.edu>
Subject: Ped Endo (Gender) Montgomery

Hi [redacted]

Can you please review attached Dep request form (yellow areas) and confirm below:

1. Are we mimicking Ped Gender Pritzker Dep? *YES, mostly*
2. Can Apex DEP name be PED GENDER MONTGOMERY same as what we have for Pritzker? Dr. Deutsch suggested ENDO MONTGOMERY. *Yes, let's keep it standard with Ped APEX DEP nomenclature*
3. Which cost center are associating this DEP with? *707820* ~~or 707050~~ Yes, *let's try to use the new Gender cost center : we can change per APEX Governance recommendation.*
4. These info will be same as Ped Gender Pritzker: phone #, fax#, WQ ID's; *Not sure, are we the one's scheduling patients into this clinic and managing Dr. [redacted] clinic schedule? If we are the one's registering patients for this clinic, then I think we need to review with the partnering team what makes sense for these patients just to make sure patients receive the correct info and we receive the wRVU funds in Peds.*

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When I s/w Dr. [redacted] yesterday, she said [redacted] will be seeing adult gender patients. those patients that transition out from Pritzker.

Summary:
Request to create a new Apex dep for [redacted]@ucsf.edu clinic. She will have one clinic session per week starting in August or September of this year. Clinic day is TBD. Funds flow to be routed to Peds Endo, home department. Clinic location will be1725 Montgomery St, Suite 250, San Francisco, CA 94111.

Thank you,
[redacted]

[redacted]
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Sent: Wednesday, April 26, 2023 3:31 PM PDT
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Please let me know if you have any further questions.

Maddie

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[redacted]

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Sent: Wednesday, April 26, 2023 10:08 AM
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Subject: Ped Endo (Gender) Montgomery

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[redacted]
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From: [redacted]@ucsf.edu>
Sent: Thursday, April 27, 2023 2:13 PM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
CC: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery
Attachment(s): "DEP Request Form Version220225-Ped Endo Montgomery4.27.23 .xlsx"

Hi Dr. Deutsch,

Got it and makes sense to remove ped. Since the dep will be adult, can you lmk who the adult practice manager is that is managing the staff, and will sort this out with them.

If the goal is for adult endo team to manage the staff who will be responsible for the associated WQ and template, then new dep for [redacted] should match your existing Endo Montgomery DEPs (except for the cost center and funds flow specific routing)

I have completed the new dep request form and would like to review/update before it's submitted.

Thank you,
[redacted]

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
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From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, April 27, 2023 3:54 PM PDT
To: [redacted]@ucsf.edu>
CC: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
[redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]

[redacted] is our manager and is cc'ed here. [redacted]'s template, schedule, inbox messages for patients seen in this clinic, referrals WQ etc will all be managed by our Montgomery Staff. What we have done for our other providers working on their own DEP is have our staff person granted access to manage their templates and WQ etc.. and the MyChart inbox items are routed to our pool.

From: [redacted]@ucsf.edu>
Sent: Thursday, April 27, 2023 2:13 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

Hi Dr. Deutsch,

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If the goal is for adult endo team to manage the staff who will be responsible for the associated WQ and template, then new dep for [redacted] should match your existing Endo Montgomery DEPs (except for the cost center and funds flow specific routing)

I have completed the new dep request form and would like to review/update before it's submitted.

Thank you,
[redacted]

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted] Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
Pediatric Developmental Medicine
UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
Clinic: 415-353-2080 Fax: 415-502-0014

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Wednesday, April 26, 2023 3:31 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

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Please let me know if you have any further questions.

Maddie

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, April 26, 2023 3:26 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]

I have cc'd Dr. Maddie Deutsch, Director of Adult Transgender Services, who should be able to answer your question.

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 11:44 AM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: FW: Ped Endo (Gender) Montgomery

Hi Drs. [redacted] Rosenthal,

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Once you confirm then I can proceed with submitting the request for Apex Govn team.

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See answers below.
Thanks,
[redacted]

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CC: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

My Chart Messages can be routed to Pool 2100062 UCSF AMB TRANSGENDER CLINICAL STAFF

[redacted] RN
Nurse Manager
360 Positive Care Clinic /Womens Specialty Health/Transgender Care
UCSF Medical Center
350 Parnassus Avenue Suite 908
San Francisco, California 94143
Cell: [redacted]
Tel: 415-353-2503
Fax: 415-353-2406
Pronouns: He, His

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
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To: [redacted]@ucsf.edu>
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From: Whitman-Walker Institute <[redacted]@whitman-walker.org> on behalf of Whitman-Walker Institute <[redacted]@wwc.ccsend.com>
Sent: Friday, April 28, 2023 8:07 AM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Gender-Affirming Care Weekly Newsletter

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Gender-Affirming Care Weekly Newsletter

April 28th, 2023

Resources

The Movement Advancement Project (MAP) released a new report analyzing every bill introduced since 2017 (through April 1, 2023) seeking to ban or restrict medically necessary care for transgender people. The report shows how the number of these bills has exploded in recent years and how the bills have become more and more extreme over time.

The report, executive summary, and infographics can be found **here**.

A current map of states banning medical care for trans youth can viewed **here**.

The State Innovation Exchange sent a letter to the Montana and Oklahoma House in support of Montana State Representative Zooey Zephyr and Oklahoma State Representative Mauree Turner.

Read the press release **here**, and the final letter **here**.

Allied elected officials interested in issuing their own letter of support can find a template **here**.

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Policy & Hill Updates

Reintroduction of the Do No Harm Act in the 118th Congress
The Act, reintroduced in the Senate this session, would restore the Religious Freedom Restoration Act's (RFRA) original intent and prohibit individuals and businesses from using religion to deny others' civil rights. Historically, RFRA has been used against LGBTQ+ people to deny them health care and undermine non-discrimination protections.

Justice Department Challenges Tennessee Law that Bans Critical, Medically Necessary Care for Transgender Youth
On Wednesday, the DOJ filed a complaint challenging Tennessee's medical care ban. The complaint states that denying medically necessary care for trans youth violates the 14th Amendment's Equal Protection Clause. The DOJ also requests the Court grant a preliminary injunction, **filed** by LGBTQ rights group last week, to prevent the law from going into effect on July 1.

Legal Advocates Sue to Block Missouri Attorney General's Anti-Transgender Rule Restricting Gender-Affirming Care
Several legal groups filed a petition "seeking a temporary restraining order to block implementation of the Missouri Attorney General's unprecedented and extreme restrictions on gender-affirming care for transgender people of all ages in Missouri," which was scheduled to go into effect on April 27.

Statement from HHS Secretary Xavier Becerra on Missouri's Emergency Regulation Restricting Access to Gender-Affirming Care
In the press release, Secretary Becerra states that the AG's regulation "is an egregious attack on the bodily autonomy of transgender people and an unconscionable interference with the practice of medicine by dedicated and trained professionals."

Ban on gender-affirming care for youth signed into law in North Dakota
Last week, North Dakota joined more than a dozen other states that now ban gender-affirming care for youth after the bill passed veto-proof majorities in both the House and the Senate.

GOP-led Florida House panel approves subpoenas to groups supporting gender-affirming care
The House Committee on Health & Human Services are demanding records from the Florida chapter of the American Academy of Pediatrics and the Florida Psychiatric Society. The records being sought include how the organizations "concluded that surgeries and hormone therapies are safe treatments for gender dysphoria."

Kansas Senate fails to override veto of gender-affirming care ban
Democratic Kansas Gov. Laura Kelly vetoed several anti-trans bills, including a gender-affirming care ban for minors. The Senate did not have the votes to override Kelly's veto.

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Media Coverage

Death threats, doxxing and panic buttons: Docs who treat trans youth are under attack
This Politico piece interviews several gender-affirming care providers who speak about the threats they've received and how the bans impact families in every state, not just those where bans have passed. Several pediatricians mentioned they felt "that by staying quiet they are protecting their institution's safety but letting down their patients. 'I know many of my colleagues feel like when we're doing what they need us to do for our protection and our institution's protection, many of us also feel like we're letting the community who needs us the most down.'"

Seven arrested after protests erupt over silencing of transgender lawmaker in Montana
This article from *The Hill* covers the story of the seven people who were arrested on Monday after demonstrating at the Montana Statehouse. These protests were in response to the continued silencing of Democratic state Rep. Zooey Zephyr by House Republicans. On Wednesday, Republicans **voted to ban** Rep. Zephyr from attending or speaking during floor sessions. She is only allowed to cast votes remotely for the remainder of the legislative session.

Listen: How We Arrived at Current Standards of Care for Trans Medicine
In this Science Friday episode, guest host Maddie Sofia talks with Hil Malatino, Assistant Professor of Women's, Gender, and Sexuality Studies and Philosophy at Penn State University, to put in perspective the history of gender-affirming care. Malatino discusses transgender medicine in the U.S. in the mid 1900s and how the standards of care have been developed over time.

Listen: Let Her Speak
In this episode of *What A Day*, hosts Tre'vell [redacted] and Josie Duffy Rice discuss the Montana Republicans' censure of Democratic Rep. Zooey Zephyr, the first openly transgender person to be elected to the state's legislature. This vote came after Rep. Zephyr said that the supporters of Montana's proposed ban on gender-affirming care for young people would have "blood on their hands."

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Submit News

Whitman-Walker Health
1377 R Street, NW, Suite 200
Washington, DC 20009

Unsubscribe madeline.deutsch@ucsf.edu

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Sent bysmar@whitman-walker.org

Obtained via CPRA by Judicial Watch, Inc.

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From: [redacted]@questfamilies.com>
Sent: Wednesday, May 03, 2023 7:57 AM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; [redacted]@alignsurgical.com>; [redacted]
[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@hsc.utah.edu>
Subject: Re: Dinner Friday

This Message Is From an External Sender
This message came from outside your organization.

Thanks Maddie,
I'm available to join inside or out. [redacted]

Warmly,
[redacted]

[redacted]

[redacted]

Pronouns: He, His, Him

Licensed Psychologist, [redacted] *| WPATH Certified Professional Member & Mentor*

Owner, Quest Family Therapy | CEO, The Gender Health Training Institute & TransFamily Alliance

www.questfamilies.com | www.genderhealthtraining.com | www.transfamilyalliance.com

Email: info@questfamilies.com

Ph: [redacted]

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> Hi all,
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> I am looking forward to Friday - it's going to be a great program, in large part due to all of your important contributions. I'd like to see if any of you would like to go out to dinner in Oakland after the program ends. Please let me know by the end of Wednesday as well as any dietary restrictions so I can make a reservation.
>
> ([redacted], I don't have [redacted] e-mail, so could you forward this on?)
>
> See you all soon!
>
> Maddie
>
> **********
> Maddie Deutsch, MD, MPH
> Professor of Clinical Family & Community Medicine

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Medical Director, UCSF Gender Affirming Health Program
UCSF Health Physician Co-Lead for Diversity, Equity, Inclusion, and Belonging
Co-Director, Differences Matter, UCSF School of Medicine
University of California - San Francisco

President, US Professional Association for Transgender Health

1725 Montgomery St, Suite 250
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415-797-7136 phone
415-353-3399 fax
Madeline.Deutsch@ucsf.edu
transcare.ucsf.edu
profiles.ucsf.edu/madeline.deutsch

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From: [redacted]@ucsf.edu>
Sent: Wednesday, May 03, 2023 10:12 AM PDT
To: [redacted]@questfamilies.com>; Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@alignsurgical.com>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@hsc.utah.edu>
Subject: Re: Dinner Friday

I'll be leaving after the conference to catch a flight to visit family and unable to join. Thank you for the invite; I wish I could join!

[redacted]

From: [redacted]@questfamilies.com>
Date: Wednesday, May 3, 2023 at 7:57 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: [redacted]@ucsf.edu>, [redacted]@ucsf.edu>, [redacted]@ucsf.edu>, [redacted]@alignsurgical.com>, [redacted]@ucsf.edu>, [redacted]@ucsf.edu>, [redacted]@ucsf.edu>, [redacted]@hsc.utah.edu>
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Owner, Quest Family Therapy | CEO, The Gender Health Training Institute & TransFamily Alliance

www.questfamilies.com | www.genderhealthtraining.com | www.transfamilyalliance.com

Email: info@questfamilies.com

Ph: [redacted]

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Thanks all for the replies. I'll look into outside seating at a place that seems likely to be ingredient-friendly. More to come!

Maddie

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[redacted]
Pronouns: He, His, Him
Licensed Psychologist, [redacted] *| WPATH Certified Professional Member & Mentor*
Owner, Quest Family Therapy | CEO, The Gender Health Training Institute & TransFamily Alliance
www.questfamilies.com | www.genderhealthtraining.com | www.transfamilyalliance.com
Email:info@questfamilies.com
Ph:[redacted]

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> On May 2, 2023, at 10:07 PM, Deutsch, Madeline <Madeline.Deutsch@ucsf.edu> wrote:
>
> Hi all,
>
> I am looking forward to Friday - it's going to be a great program, in large part due to all of your important contributions. I'd like to see if any of you would like to go out to dinner in Oakland after the program ends. Please let me know by the end of Wednesday as well as any dietary restrictions so I can make a reservation.
>
> ([redacted], I don't have [redacted] e-mail, so could you forward this on?)
>
> See you all soon!
>
> Maddie
>
> **********
> Maddie Deutsch, MD, MPH

Obtained via CPRA by Judicial Watch, Inc.

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Professor of Clinical Family & Community Medicine
Medical Director, UCSF Gender Affirming Health Program
UCSF Health Physician Co-Lead for Diversity, Equity, Inclusion, and Belonging
Co-Director, Differences Matter, UCSF School of Medicine
University of California - San Francisco

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1725 Montgomery St, Suite 250
San Francisco, CA 94111
415-797-7136 phone
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Madeline.Deutsch@ucsf.edu
transcare.ucsf.edu
profiles.ucsf.edu/madeline.deutsch

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From: [redacted]@ucsf.edu>
Sent: Wednesday, May 03, 2023 8:02 PM PDT
To: [redacted]@ucsf.edu>; Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
CC: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery
Attachment(s): "DEP Request Form Version220225-Endo Montgomery5.3.23 .xlsx","Incident INC8944140 Opened.msg"

HI [redacted]

Here is the DEPT Request form and ticket submitted to start the process. when you return pls review the form (yellow sections) to complete as we will need to resubmit/present at the next Apex Governance Committee meeting.
Ticket/request will be reviewed by Apex team, then we (you and I) will be invited to the Apex Governance meeting to finalize. Then they will create the new dep.

Thank you,
[redacted]

Ticket #: INC8944140
Description: Requesting a new DEP at 1725 Montgomery Street location.

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted] Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
Pediatric Developmental Medicine
UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
Clinic: 415-353-2080 Fax: 415-502-0014

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From: [redacted]@ucsf.edu>
Sent: Thursday, April 27, 2023 3:58 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

My Chart Messages can be routed to Pool 2100062 UCSF AMB TRANSGENDER CLINICAL STAFF

[redacted] RN
Nurse Manager
360 Positive Care Clinic /Womens Specialty Health/Transgender Care
UCSF Medical Center
350 Parnassus Avenue Suite 908
San Francisco, California 94143
Cell: [redacted]
Tel: 415-353-2503
Fax: 415-353-2406
Pronouns: He, His

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, April 27, 2023 3:55 PM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]

[redacted] is our manager and is cc'ed here. [redacted]s template, schedule, inbox messages for patients seen in this clinic, referrals WQ etc will all be managed by our Montgomery Staff. What we have done for our other providers working on their own DEP is have our staff person granted access to manage their templates and WQ etc.. and the MyChart inbox items are routed to our pool.

From: [redacted]@ucsf.edu>
Sent: Thursday, April 27, 2023 2:13 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

Hi Dr. Deutsch,

Got it and makes sense to remove ped. Since the dep will be adult, can you lmk who the adult practice manager is that is managing the staff, and will sort this out with them.

If the goal is for adult endo team to manage the staff who will be responsible for the associated WQ and template, then new dep for [redacted] should match your existing Endo Montgomery DEPs (except for the cost center and funds flow specific routing)

I have completed the new dep request form and would like to review/update before it's submitted.

Thank you,
[redacted]

Obtained via CPRA by Judicial Watch, Inc.

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Wednesday, April 26, 2023 3:31 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]

[redacted] will be seeing only adult patients in our adult clinic. It might make more sense to name the DEP without the word "ped" in it to avoid system confusion.

[redacted] will function operationally as part of our clinic. We are creating a DEP for her only to facilitate the Funds Flow arrangement. We will handle all scheduling, as well as inbox items/pools that come in for her patients seen at this location.

Please let me know if you have any further questions.

Maddie

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, April 26, 2023 3:26 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]

I have cc'd Dr. Maddie Deutsch, Director of Adult Transgender Services, who should be able to answer your question.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology

Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635

San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 11:44 AM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: FW: Ped Endo (Gender) Montgomery

Hi Drs. [redacted] Rosenthal,

Can you clarify who will be scheduling patients for [redacted] at Montgomery location?
See [redacted] response below in blue italic.

Once you confirm then I can proceed with submitting the request for Apex Govn team.

Thank you,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 11:04 AM
To: [redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Hi [redacted]
See answers below.
Thanks,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 10:08 AM
To: [redacted]@ucsf.edu>
Subject: Ped Endo (Gender) Montgomery

Hi [redacted]

Can you please review attached Dep request form (yellow areas) and confirm below:

1. Are we mimicking Ped Gender Pritzker Dep? *YES, mostly*
2. Can Apex DEP name be PED GENDER MONTGOMERY same as what we have for Pritzker? Dr. Deutsch suggested ENDO MONTGOMERY. *Yes, let's keep it standard with Ped APEX DEP nomenclature*
3. Which cost center are associating this DEP with? *707820* ~~or 707050~~ Yes, *let's try to use the new Gender cost center ; we can change per APEX Governance recommendation.*
4. These info will be same as Ped Gender Pritzker: phone #, fax#, WQ ID's; *Not sure, are we the one's scheduling patients into this clinic and managing Dr. [redacted]'s clinic schedule? If we are the one's registering patients for this clinic, then I think we need to review with the partnering team what makes sense for these patients just to make sure patients receive the correct info and we receive the wRVU funds in Peds.*

When I s/w Dr. [redacted] yesterday, she said [redacted] will be seeing adult gender patients. those patients that transition out from Pritzker.

Summary:
Request to create a new Apex dep for [redacted] [redacted]@ucsf.edu clinic. She will have one clinic session per week starting in August or September of this year. Clinic day is TBD. Funds flow to be routed to Peds Endo, home department. Clinic location will be 1725 Montgomery St, Suite 250, San Francisco, CA 94111.

Thank you.
[redacted]

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted] Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
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From: [redacted]@questfamilies.com>
Sent: Thursday, May 04, 2023 3:12 PM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@alignsurgical.com>; [redacted]@alignsurgical.com>; [redacted]@gmail.com>
Subject: Re: Dinner Friday

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[redacted]

Pronouns: He, His, Him

Licensed Psychologist, [redacted] *| WPATH Certified Professional Member & Mentor*

Owner, Quest Family Therapy | CEO, The Gender Health Training Institute & TransFamily Alliance

www.questfamilies.com | www.genderhealthtraining.com | www.transfamilyalliance.com

Email: info@questfamilies.com

Ph: [redacted]

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[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, May 4, 2023 7:05 AM
To: [redacted]@alignsurgical.com>; [redacted]@alignsurgical.com>
Cc: [redacted]@ucsf.edu>; [redacted]@questfamilies.com>; [redacted]@gmail.com>
Subject: Re: Dinner Friday

Great, thanks [redacted] I've made a reservation for 6 people for 7pm at Chop Bar (https://www.oaklandchopbar.com/), outdoor seating and looks like they have some menu items that can be ingredient-sensitive.

Your table has been confirmed!
An email confirmation has been sent to you.
Confirmation #73440

Chop Bar

Friday, May 5
7:00 pm
6 People
Outdoor • Standard
190 4th St Oakland, CA, 94607

Modify
Cancel
Message

Add a special request (optional)

Special Occasion

What to know before you go

Important dining information
We have a 15 minute grace period. Please call us if you are running later than 15 minutes after your reservation time.

A note from the restaurant
Reservations for parties of 6+ have a 2 hour time limit on tables so we can accommodate all groups.

See you all soon!

Maddie

From: [redacted]@alignsurgical.com>

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Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>;
[redacted]@hsc.utah.edu>; [redacted]@questfamilies.com>
Subject: Re: Dinner Friday

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Thanks, Maddie. You're so thoughtful. Count me in. No restrictions on my end. I've added [redacted] email to this chain.

Regards,
[redacted]

[redacted]
Founder & Chief Executive Officer

Align Surgical Associates, Inc.
2299 Post Street, Suite 207, San Francisco, CA 94115
[redacted]
E: [redacted]alignsurgical.com

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Please do not email any urgent medical information to our office. For urgent matters please call our office at [redacted] (calls after hours will be directed to our on-call advice line). If you do not receive a timely reply to your email, please call our office.

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Sent: Thursday, May 04, 2023 3:16 PM PDT
To: [redacted]@questfamilies.com>
CC: [redacted]@ucsf.edu>; [redacted]@alignsurgical.com>; [redacted]@alignsurgical.com>; [redacted]@gmail.com>
Subject: Re: Dinner Friday

Indeed. And there is an outside veranda there too.

From: [redacted]@questfamilies.com>
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To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
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[redacted]
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[redacted]

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Department of Pediatrics
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Your table has been confirmed!
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Confirmation #73440

Chop Bar

Friday, May 5
7:00 pm
6 People
Outdoor • Standard
190 4th St Oakland, CA, 94607

Modify
Cancel
Message

Add a special request (optional)

Special Occasion

What to know before you go

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Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@hsc.utah.edu>; [redacted]@questfamilies.com>
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Regards,
[redacted]

[redacted]
Founder & Chief Executive Officer

Align Surgical Associates, Inc.
2299 Post Street, Suite 207, San Francisco, CA 94115
[redacted]
[redacted]@alignsurgical.com

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Please do not email any urgent medical information to our office. For urgent matters please call our office at [redacted] (calls after hours will be directed to our on-call advice line). If you do not receive a timely reply to your email, please call our office.

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Maddie Deutsch, MD, MPH
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From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, May 04, 2023 3:41 PM PDT
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
CC: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Thanks everyone. I know Al is out this week, I'll connect with him on this next week.

Best,

Maddie

From: [redacted]@ucsf.edu>
Sent: Wednesday, May 3, 2023 8:02 PM
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Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
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HI [redacted]

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Ticket/request will be reviewed by Apex team, then we (you and I) will be invited to the Apex Governance meeting to finalize. Then they will create the new dep.

Thank you,
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675 18th Street, 2nd floor, SF Ca 94143
Clinic: 415-353-2080 Fax: 415-502-0014

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From: [redacted]@ucsf.edu>
Sent: Thursday, April 27, 2023 3:58 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

My Chart Messages can be routed to Pool 2100062 UCSF AMB TRANSGENDER CLINICAL STAFF

[redacted] RN
Nurse Manager
360 Positive Care Clinic /Womens Specialty Health/Transgender Care
UCSF Medical Center
350 Parnassus Avenue Suite 908
San Francisco, California 94143
Cell: [redacted]
Tel: 415-353-2503
Fax: 415-353-2406
Pronouns: He, His

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, April 27, 2023 3:55 PM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]

[redacted] is our manager and is cc'ed here. [redacted]'s template, schedule, inbox messages for patients seen in this clinic, referrals WQ etc will all be managed by our Montgomery Staff. What we have done for our other providers working on their own DEP is have our staff person granted access to manage their templates and WQ etc.. and the MyChart inbox items are routed to our pool.

From: [redacted]@ucsf.edu>
Sent: Thursday, April 27, 2023 2:13 PM

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Obtained via CPRA by Judicial Watch, Inc.

To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

Hi Dr. Deutsch,

Got it and makes sense to remove ped. Since the dep will be adult, can you lmk who the adult practice manager is that is managing the staff, and will sort this out with them.

If the goal is for adult endo team to manage the staff who will be responsible for the associated WQ and template, then new dep for [redacted] should match your existing Endo Montgomery DEPs (except for the cost center and funds flow specific routing)

I have completed the new dep request form and would like to review/update before it's submitted.

Thank you,
[redacted]

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Wednesday, April 26, 2023 3:31 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]

[redacted] will be seeing only adult patients in our adult clinic. It might make more sense to name the DEP without the word "ped" in it to avoid system confusion.

[redacted] will function operationally as part of our clinic. We are creating a DEP for her only to facilitate the Funds Flow arrangement. We will handle all scheduling, as well as inbox items/pools that come in for her patients seen at this location.

Please let me know if you have any further questions.

Maddie

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, April 26, 2023 3:26 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]

I have cc'd Dr. Maddie Deutsch, Director of Adult Transgender Services, who should be able to answer your question.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his
Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 11:44 AM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: FW: Ped Endo (Gender) Montgomery

Hi Drs. [redacted] Rosenthal,

Can you clarify who will be scheduling patients for [redacted] at Montgomery location?
See [redacted]s response below in blue italic.

Once you confirm then I can proceed with submitting the request for Apex Govn team.

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Thank you,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 11:04 AM
To: [redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]
See answers below.
Thanks,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 10:08 AM
To: [redacted]@ucsf.edu>
Subject: Ped Endo (Gender) Montgomery

Hi Jo,

Can you please review attached Dep request form (yellow areas) and confirm below:

1. Are we mimicking Ped Gender Pritzker Dep?*YES, mostly*
2. Can Apex DEP name bePED GENDER MONTGOMERY same as what we have for Pritzker? Dr. Deutsch suggested ENDO MONTGOMERY. *Yes, let's keep it standard with Ped APEX DEP nomenclature*
3. Which cost center are associating this DEP with? *707820*~~*or 707050*~~ Yes, *let's try to use the new Gender cost center ; we can change per APEX Governance recommendation.*
4. These info will be same as Ped Gender Pritzker: phone #, fax#, WQ ID's;*Not sure, are we the one's scheduling patients into this clinic and managing Dr.* [redacted]*'s clinic schedule? If we are the one's registering patients for this clinic, then I think we need to review with the partnering team what makes sense for these patients just to make sure patients receive the correct info and we receive the wRVU funds in Peds.*

When I s/w Dr. [redacted] yesterday, she said [redacted] will be seeing adult gender patients. those patients that transition out from Pritzker.

Summary:
Request to create a new Apex dep for [redacted]@ucsf.edu clinic. She will have one clinic session per week starting in August or September of this year. Clinic day is TBD. Funds flow to be routed to Peds Endo, home department. Clinic location will be1725 Montgomery St, Suite 250, San Francisco, CA 94111.

Thank you,
[redacted]

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted] Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
Pediatric Developmental Medicine
UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
Clinic: 415-353-2080 Fax: 415-502-0014

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From: [redacted]@ucsf.edu>
Sent: Thursday, May 04, 2023 5:47 PM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: Dinner Friday

Thank for you the invitation. Unfortunately I have plans already and will not be able to join. Looking forward to tomorrow! [redacted]

On May 3, 2023, at 10:54 AM, Deutsch, Madeline <Madeline.Deutsch@ucsf.edu> wrote:

Thanks all for the replies. I'll look into outside seating at a place that seems likely to be ingredient-friendly. More to come!

Maddie

From: [redacted]@questfamilies.com>
Sent: Wednesday, May 3, 2023 7:57 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@alignsurgical.com>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@hsc.utah.edu>
Subject: Re: Dinner Friday

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Thanks Maddie,
I'm available to join inside or out. I have a bunch of restrictions, so may not eat as it's hard for restaurants to serve me.

Warmly,
[redacted]

[redacted]

[redacted]

Pronouns: He, His, Him

Licensed Psychologist, [redacted] *| WPATH Certified Professional Member & Mentor*

Owner, Quest Family Therapy | CEO, The Gender Health Training Institute & TransFamily Alliance

www.questfamilies.com | www.genderhealthtraining.com | www.transfamilyalliance.com

Email:info@questfamilies.com

Ph:[redacted]

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On May 2, 2023, at 10:07 PM, Deutsch, Madeline <Madeline.Deutsch@ucsf.edu> wrote:

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Hi all,

I am looking forward to Friday - it's going to be a great program, in large part due to all of your important contributions. I'd like to see if any of you would like to go out to dinner in Oakland after the program ends. Please let me know by the end of Wednesday as well as any dietary restrictions so I can make a reservation.

([redacted], I don't have [redacted] e-mail, so could you forward this on?)

See you all soon!

Maddie

****
Maddie Deutsch, MD, MPH
Professor of Clinical Family & Community Medicine
Medical Director, UCSF Gender Affirming Health Program
UCSF Health Physician Co-Lead for Diversity, Equity, Inclusion, and Belonging
Co-Director, Differences Matter, UCSF School of Medicine
University of California - San Francisco

President, US Professional Association for Transgender Health

1725 Montgomery St, Suite 250
San Francisco, CA 94111
415-797-7136 phone
415-353-3399 fax
Madeline.Deutsch@ucsf.edu
transcare.ucsf.edu
profiles.ucsf.edu/madeline.deutsch

Obtained via CPRA by Judicial Watch, Inc.

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From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Friday, May 05, 2023 2:16 PM PDT
To: [redacted]@questfamilies.com>
CC: [redacted]@ucsf.edu>; [redacted]@alignsurgical.com>; [redacted]@alignsurgical.com>; [redacted]@gmail.com>
Subject: Re: Dinner Friday

Hi all - a good chuckle - I had forgotten that the conference was at the SF Hyatt rather than the Oakland Marriott, where it had always been prior

You all were very polite in not correcting me and just politely declining.

Anyhow, thanks for all you do and for all of your hard work today.

Cheers,

Maddie

From: [redacted]@questfamilies.com>
Sent: Thursday, May 4, 2023 3:12 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@alignsurgical.com>; [redacted]@alignsurgical.com>; [redacted]@gmail.com>
Subject: Re: Dinner Friday

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That works well for me. And the hotel bar is in a huge open space, so it's kind of like being outside, so maybe [redacted] can join as well. They also have decent bar food.

[redacted] ***Ph.D.***
Pronouns: He, His, Him
Licensed Psychologist, [redacted] *| WPATH Certified Professional Member & Mentor*
Owner, Quest Family Therapy | CEO, The Gender Health Training Institute & TransFamily Alliance
www.questfamilies.com | www.genderhealthtraining.com | www.transfamilyalliance.com
Email:info@questfamilies.com
Ph: [redacted]

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> On May 4, 2023, at 3:09 PM, Deutsch, Madeline <Madeline.Deutsch@ucsf.edu> wrote:
>
> Ok folks, dinner is cancelled! See you all tomorrow, and thanks for all you do!
>
> ---
>
> **From:** Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
> **Sent:** Thursday, May 4, 2023 10:23 AM
> **To:** [redacted]@ucsf.edu>; [redacted]@alignsurgical.com>; [redacted]@alignsurgical.com>
> **Cc:** [redacted]@questfamilies.com>; [redacted]@gmail.com>
> **Subject:** Re: Dinner Friday
>
> Ok thanks [redacted], [redacted] had to cancel due to a last minute conflict, and [redacted] may not even be able to eat. Maybe it will be better for us to just grab a drink at the hotel bar after, and cancel dinner all together?
>
> ---
>
> **From:** [redacted] <[redacted]@ucsf.edu>
> **Sent:** Thursday, May 4, 2023 10:21 AM

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To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@alignsurgical.com>; [redacted]@alignsurgical.com>
Cc: [redacted]@questfamilies.com>; [redacted]@gmail.com>
Subject: Re: Dinner Friday

Thanks so much, Maddie. I also wanted to add that if I'm the only one restricted to outdoor eating, I'm glad to forego dinner if others would like a warmer, inside experience.

[redacted], Ph.D.
Director of Mental Health, Child and Adolescent Gender Center
Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
San Francisco, CA 94158
e-mail: [redacted]@ucsf.edu

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, May 4, 2023 7:05 AM
To: [redacted]@alignsurgical.com>; [redacted]@alignsurgical.com>
Cc: [redacted]@ucsf.edu>; [redacted]@questfamilies.com>; [redacted]@gmail.com>
Subject: Re: Dinner Friday

Great, thanks [redacted], I've made a reservation for 6 people for 7pm at Chop Bar (https://www.oaklandchopbar.com/), outdoor seating and looks like they have some menu items that can be ingredient-sensitive.

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Your table has been confirmed!

An email confirmation has been sent to you.
Confirmation #73440

Chop Bar

Friday, May 5
7:00 pm
6 People
Outdoor • Standard
190 4th St Oakland, CA, 94607

Modify
Cancel
Message

Add a special request (optional)

Special Occasion

What to know before you go

Important dining information
We have a 15 minute grace period. Please call us if you are running later than 15 minutes after your reservation time.

A note from the restaurant
Reservations for parties of 6+ have a 2 hour time limit on tables so we can accommodate all groups.

See you all soon!

Maddie

From: [redacted]@alignsurgical.com>
Sent: Wednesday, May 3, 2023 7:53 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@alignsurgical.com>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@hsc.utah.edu>; [redacted]@questfamilies.com>
Subject: Re: Dinner Friday

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Thanks, Maddie. You're so thoughtful. Count me in. No restrictions on my end. I've added [redacted] email to this chain.

Regards,
[redacted]

[redacted]**M.D.** (he/him/his)
Founder & Chief Executive Officer

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Align Surgical Associates, Inc.
2299 Post Street, Suite 207, San Francisco, CA 94115
[redacted]
E: [redacted]@alignsurgical.com

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On May 2, 2023, at 10:07 PM, Deutsch, Madeline <Madeline.Deutsch@ucsf.edu> wrote:

Hi all,

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[redacted], I don't have [redacted] e-mail, so could you forward this on?)

See you all soon!

Maddie

****
Maddie Deutsch, MD, MPH
Professor of Clinical Family & Community Medicine
Medical Director, UCSF Gender Affirming Health Program
UCSF Health Physician Co-Lead for Diversity, Equity, Inclusion, and Belonging
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From: [redacted]@questfamilies.com>
Sent: Friday, May 05, 2023 2:59 PM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@alignsurgical.com>; [redacted]@alignsurgical.com>; [redacted]@gmail.com>
Subject: Re: Dinner Friday

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LOL, I wondered. Just assumed most folks live in the [redacted].

[redacted] ***Ph.D.***

Pronouns: He, His, Him

Licensed Psychologist, PSY22570 | WPATH Certified Professional Member & Mentor

Owner, Quest Family Therapy | CEO, The Gender Health Training Institute & TransFamily Alliance

www.questfamilies.com | www.genderhealthtraining.com | www.transfamilyalliance.com

Email: info@questfamilies.com

Ph: [redacted]

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> You all were very polite in not correcting me and just politely declining.
>
> Anyhow, thanks for all you do and for all of your hard work today.
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> Cheers,
>
> Maddie
>
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[redacted]
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Department of Pediatrics
UCSF Benioff Children's Hospital
1825 Fourth St., Sixth Floor
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Friday, May 5
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Cancel
Message

Add a special request (optional)

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Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@hsc.utah.edu>; [redacted]@questfamilies.com>
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[redacted]

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Obtained via CPRA by Judicial Watch, Inc.

[redacted] (he/him/his)
Founder & Chief Executive Officer

Align Surgical Associates, Inc.
2299 Post Street, Suite 207, San Francisco, CA 94115
[redacted]@alignsurgical.com

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([redacted] I don't have [redacted] e-mail, so could you forward this on?)

See you all soon!

Maddie

****
Maddie Deutsch, MD, MPH
Professor of Clinical Family & Community Medicine
Medical Director, UCSF Gender Affirming Health Program
UCSF Health Physician Co-Lead for Diversity, Equity, Inclusion, and Belonging
Co-Director, Differences Matter, UCSF School of Medicine
University of California - San Francisco

President, US Professional Association for Transgender Health

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profiles.ucsf.edu/madeline.deutsch

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From: [redacted]@ucsf.edu>
Sent: Monday, May 08, 2023 12:57 PM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@ucsf.edu>
CC: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

Hi all,

The DEP Governance meeting invite for tomorrow just came in. I will forward to [redacted]now and will plan to attend. This request is on their agenda. Thanks.

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted] Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
Pediatric Developmental Medicine
UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
Clinic: 415-353-2080 Fax: 415-502-0014

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, May 4, 2023 3:41 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Thanks everyone. I know [redacted] is out this week, I'll connect with him on this next week.

Best,

Maddie

From: [redacted]@ucsf.edu>
Sent: Wednesday, May 3, 2023 8:02 PM
To: [redacted]@ucsf.edu>; Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

HI [redacted]

Here is the DEPT Request form and ticket submitted to start the process. when you return pls review the form (yellow sections) to complete as we will need to resubmit/present at the next Apex Governance Committee meeting.
Ticket/request will be reviewed by Apex team, then we (you and I) will be invited to the Apex Governance meeting to finalize. Then they will create the new dep.

Thank you,
[redacted]

Ticket #: INC8944140
Description: Requesting a new DEP at 1725 Montgomery Street location.

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted] Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
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UC Box 3132
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From: [redacted]@ucsf.edu>

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Sent: Thursday, April 27, 2023 3:58 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

My Chart Messages can be routed to Pool 2100062 UCSF AMB TRANSGENDER CLINICAL STAFF

[redacted]RN
Nurse Manager
360 Positive Care Clinic /Womens Specialty Health/Transgender Care
UCSF Medical Center
350 Parnassus Avenue Suite 908
San Francisco, California 94143
Cell: [redacted]
Tel: 415-353-2503
Fax: 415-353-2406
Pronouns: He, His

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, April 27, 2023 3:55 PM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]

[redacted]is our manager and is cc'ed here. [redacted]'s template, schedule, inbox messages for patients seen in this clinic, referrals WQ etc will all be managed by our Montgomery Staff. What we have done for our other providers working on their own DEP is have our staff person granted access to manage their templates and WQ etc., and the MyChart inbox items are routed to our pool.

From: [redacted]@ucsf.edu>
Sent: Thursday, April 27, 2023 2:13 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

Hi Dr. Deutsch,

Got it and makes sense to remove ped. Since the dep will be adult, can you lmk who the adult practice manager is that is managing the staff, and will sort this out with them.

If the goal is for adult endo team to manage the staff who will be responsible for the associated WQ and template, then new dep for [redacted] should match your existing Endo Montgomery DEPs (except for the cost center and funds flow specific routing)

I have completed the new dep request form and would like to review/update before it's submitted.

Thank you,
[redacted]

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Wednesday, April 26, 2023 3:31 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]

[redacted] will be seeing only adult patients in our adult clinic. It might make more sense to name the DEP without the word "ped" in it to avoid system confusion.

[redacted] will function operationally as part of our clinic. We are creating a DEP for her only to facilitate the Funds Flow arrangement. We will handle all scheduling, as well as inbox items/pools that come in for her patients seen at this location.

Please let me know if you have any further questions.

Maddie

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, April 26, 2023 3:26 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]

I have cc'd Dr. Maddie Deutsch, Director of Adult Transgender Services, who should be able to answer your question.

Thanks,

Steve

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Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his
Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 11:44 AM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: FW: Ped Endo (Gender) Montgomery

Hi Drs. [redacted]Rosenthal,

Can you clarify who will be scheduling patients for [redacted] at Montgomery location?
See [redacted]s response below in blue italic.

Once you confirm then I can proceed with submitting the request for Apex Govn team.

Thank you,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 11:04 AM
To: [redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted],
See answers below.
Thanks,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 10:08 AM
To: [redacted]@ucsf.edu>
Subject: Ped Endo (Gender) Montgomery

Hi [redacted]

Can you please review attached Dep request form (yellow areas) and confirm below:

1. Are we mimicking Ped Gender Pritzker Dep? *YES, mostly*
2. Can Apex DEP name be PED GENDER MONTGOMERY same as what we have for Pritzker? Dr. Deutsch suggested ENDO MONTGOMERY. *Yes, let's keep it standard with Ped APEX DEP nomenclature*
3. Which cost center are associating this DEP with? *707820* ~~or 707050~~ Yes, *let's try to use the new Gender cost center ; we can change per APEX Governance recommendation.*
4. These info will be same as Ped Gender Pritzker: phone #, fax#, WQ ID's; *Not sure, are we the one's scheduling patients into this clinic and managing Dr.* [redacted]'s *clinic schedule? If we are the one's registering patients for this clinic, then I think we need to review with the partnering team what makes sense for these patients just to make sure patients receive the correct info and we receive the wRVU funds in Peds.*

When I s/w [redacted]yesterday, she said [redacted] will be seeing adult gender patients. those patients that transition out from Pritzker.

Summary:
Request to create a new Apex dep for [redacted]@ucsf.edu clinic. She will have one clinic session per week starting in August or September of this year. Clinic day is TBD. Funds flow to be routed to Peds Endo, home department. Clinic location will be 1725 Montgomery St, Suite 250, San Francisco, CA 94111.

Thank you,
[redacted]

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted] Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811

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Pediatric Developmental Medicine
UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
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From: [redacted]@sfdph.org>
Sent: Monday, May 15, 2023 10:46 AM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Gender Affirming Surgery Referral Process

This Message Is From an External Sender
This message came from outside your organization.

Hi Dr. Deutsch,

I recently received some updated referral process info and updated gender affirming surgical assessment forms from different organizations reflecting the new SOC8 changes and I wanted to see if the UCSF gender affirming surgery mental health assessment form and process has changed at all since last year? I checked on your UCSF website but I wasn't able to locate the assessment form that we used last year. I'm sure I must be overlooking something, but would you mind sending me the link the assessment form so I can forward it to our clinical staff? Thanks so much.

Sincerely,

[redacted]
Sr. Behavioral Health Clinician
San Francisco Department of Public Health
South Van Ness Adult Behavioral Health Services
755 South Van Ness Ave, San Francisco, CA 94110
[redacted]

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Wednesday, May 17, 2023 12:42 PM PDT
To: [redacted]@ucsf.edu>
Subject: Fw: Gender Affirming Surgery Referral Process

Hi [redacted], could you connect with this provider to loop them in to our current flows? Thanks!

From: [redacted]@sfdph.org>
Sent: Monday, May 15, 2023 10:46 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Gender Affirming Surgery Referral Process

This Message Is From an External Sender
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Hi Dr. Deutsch,

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Sincerely,

[redacted]
Sr. Behavioral Health Clinician
San Francisco Department of Public Health
South Van Ness Adult Behavioral Health Services
755 South Van Ness Ave, San Francisco, CA 94110
[redacted]

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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From: [redacted]@ucsf.edu>
Sent: Wednesday, May 17, 2023 12:43 PM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Gender Affirming Surgery Referral Process

Of course!

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Wednesday, May 17, 2023 12:42 PM
To: [redacted]@ucsf.edu>
Subject: Fw: Gender Affirming Surgery Referral Process

Hi [redacted], could you connect with this provider to loop them in to our current flows? Thanks!

From: [redacted]@sfdph.org>
Sent: Monday, May 15, 2023 10:46 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Gender Affirming Surgery Referral Process

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Hi Dr. Deutsch,

I recently received some updated referral process info and updated gender affirming surgical assessment forms from different organizations reflecting the new SOC8 changes and I wanted to see if the UCSF gender affirming surgery mental health assessment form and process has changed at all since last year? I checked on your UCSF website but I wasn't able to locate the assessment form that we used last year. I'm sure I must be overlooking something, but would you mind sending me the link the assessment form so I can forward it to our clinical staff? Thanks so much.

Sincerely,

[redacted]
Sr. Behavioral Health Clinician
San Francisco Department of Public Health
South Van Ness Adult Behavioral Health Services
755 South Van Ness Ave, San Francisco, CA 94110
[redacted]

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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From: Elsevier Journal Alerts <journals@notification.elsevier.com>
Sent: Thursday, May 18, 2023 2:17 AM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Annals of Emergency Medicine: June 2023 (Volume 81, Issue 6)

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Table of Contents

Airway

First-Attempt Intubation Success Among Emergency Medicine Trainees by Laryngoscopic Device and Training Year: A National Emergency Airway Registry Study

The Importance of Median Glossoepiglottic Fold Engagement on Laryngeal View and Tracheal Intubation Success in Children

The Pediatric Bougie for the First Tracheal Intubation Attempt in Critically Ill Children

Images in Emergency Medicine

Elderly Woman With Abdominal Distension

Man With Chest Pain After a Traffic Crash

Emergency Medical Services

Out-of-Hospital Presentation and Management of Asthma and Chronic Obstructive Pulmonary Disease Exacerbations in the United States: A Nationwide Retrospective Cohort Study

Effectiveness of Lay Bystander Hands-Only Cardiopulmonary Resuscitation on a Mattress versus the Floor: A Randomized Cross-Over Trial

Occupational Accidents Among Search and Rescue Providers During Mountain Rescue Operations and Training Events
Open Access

The Practice of Emergency Medicine

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Workplace Mistreatment, Career Choice Regret, and Burnout in Emergency Medicine Residency Training in the United States
Open Access

A Qualitative Study of Emergency Physicians' and Nurses' Experiences Caring for Patients With Psychiatric Conditions and/or Substance Use Disorders
Open Access

General Medicine

Use of Real-Time Information to Predict Future Arrivals in the Emergency Department

Prospective External Validation of a Commercial Model Predicting the Likelihood of Inpatient Admission From the Emergency Department

The Devil Is in the Implementation: Beyond Statistical Validation of the Epic Integrated Admission Prediction Model

Clinical Policy Executive Summary

Clinical Policy: Critical Issues in the Evaluation and Management of Emergency Department Patients With Suspected Appendicitis: Approved by ACEP Board of Directors February 1, 2023

Images in Emergency Medicine

Teenage Boy With a Painful Elbow

Man With Neck Swelling

Woman with chest pain

Elderly Woman With Recurrent Vomiting

Older Man With Blunt Abdominal Trauma

Young Woman With Vulvar Mass

Woman With Abdominal Pain

A Case of Pediatric Rash

Change of Shift

One Big Cry

Annals of Emergency Medicine Journal Club

Tenecteplase to Replace Alteplase? Comparing Thrombolytic Therapies for Acute Ischemic Stroke: June 2023 Annals of Emergency Medicine Journal Club

Research Letter

Protecting Survivors of Intimate Partner Violence Under the Cures Act

Correspondence

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The ChatGPT Era: Artificial Intelligence in Emergency Medicine

Epic Fail? Try Again

In Reply to Michael Levine, Published December 2022, Pages 525-572

Frontmatter

Table of Contents

Masthead

What's Coming in Annals * July 2023

Global Research Highlights

Global Research Highlights

Information for Readers

Correspondence

Calendar

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Speaker and Session Information Form

Full name and titles *(M.D., D.O., R.N., Ph.D., etc.)* as you would like them to appear:

Maddie Deutsch, MD, MPH

Academic and professional positions as you would like them to appear in the course syllabus:

Professor of Clinical Family & Community Medicine, Medical Director UCSF Gender Affirming Health Program

Biographical sketch (6-8 sentences):

Dr. Deutsch is the Medical Director for the UCSF Gender Affirming Health Program, and a Professor of Clinical Family & Community Medicine at the University of California – San Francisco. Dr. Deutsch has cared for thousands of transgender patients since 2006. She has more than 50 peer reviewed publications in areas of gender affirming and transgender health, and has authored or co-authored numerous textbook chapters. She is currently the President of the US Professional Association for Transgender Health, and on the Board of Directors of the World Professional Association for Transgender Health. She was the lead author for the chapter on Primary Care in the recent WPATH 8th Version Standards of Care.

Work email *(include email address of assistant, if applicable)*:

Madeline.deutsch@ucsf.edu

Cell phone: [redacted] **Work phone:**

Address for delivery of honorarium:

[redacted]

Marketing Highlight (optional): Please list any personal achievements within the last year OR late-breaking information regarding your session to be highlighted (2-4 sentences):

Dr. Deutsch was the chapter lead for Primary Care in the recent WPATH Standards of Care 8th Version

Official Presentation Title (as it will be on your presentation title slide - 60 characters or less with spaces):

Primary and Preventative Health Needs for Transgender People

Presentation LONG Description (3-4 sentences - 420 characters or less with spaces):

Example: Flu season is here. Get your important influenza questions answered during this 30-minute course. Learn through a brief and practical patient case followed by answers to commonly asked questions and an open Q&A period.

Transgender and gender diverse people require access to primary care that is competent, culturally grounded, evidence based, and accessible. Learn about ways to improve your office environment, cardiovascular health considerations, cancer screening, and epidemiologic considerations for this population. The session will include didactic content as well as Q and A.

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Presentation Short Description (1 sentence - 160 characters or less with spaces):
Example: Get your important influenza questions answered during this 30-minute course covering a brief patient case, answers commonly asked questions, and an open Q&A period.

Important considerations and updates on the primary care needs of transgender and gender diverse people.

Learning Objectives (2-5 drafted):

1. Recognize approaches to collecting and using chosen name and pronoun in clinic
2. Understand how to frame discussions with patients about cardiovascular risk when taking hormone therapy
3. Summarize key considerations in cancer screening among transgender populations
4.
5.

Pre/Post Questions (3-4 drafted, with answer options and rationale. Learners will complete these before and after your session. Necessary for CME credit. See example questions below):

1. Which of the following should be collected in clinical contexts?
    a. Chosen name and pronoun
    b. Gender Identity
    c. Birth Assigned Sex
    d. All of the above
    e. Correct answer: D – Chosen name and pronoun are essential for patients to feel comfortable and respected in clinic. Failing to refer to a patient by their chosen name and pronoun can lead to patients feeling that their identity is not being respected. Gender Identity and Birth sex both need to be recorded to accurately identify transgender patients as well as cisgender patients, to allow comparisons between groups.
2. Thromboembolic disease in transgender patients:
    a. Estradiol use confers a significant risk regardless of the type used
    b. Transdermal estradiol confers a lower risk
    c. History of a prothrombotic mutation is an absolute contraindication to estrogen therapy
    d. None of the above
    e. Correct answer: B – Transdermal estradiol does not undergo first-pass metabolism, and therefore does not cause a disruption of clotting factor synthesis balance. Patients with a prothrombotic mutation or with a history of unprovoked VTE may still be treated with transdermal estradiol after a shared decision making discussion with the patient.
3. With regard to breast cancer screening in transgender people:
    a. Breast cancer risk is likely increased when taking estrogen
    b. Evidence demonstrates that breast cancer screening is not needed after top surgery
    c. Long term, screening based studies are lacking
    d. A and C
    e. Correct answer rationale (1-2 sentences): Long term, population-level, screening studies on breast cancer risk in trans populations have not been conducted. Some preliminary evidence suggests a small increase in risk of breast cancer with estrogen use. Data are lacking to guide approaches to screening in those who have undergone top surgery.

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Pre/Post Question Examples: Below are a few examples. The first question is a "case-based" question, the second is a TRUE / FALSE type question, the third is a question strictly assessing facts, and the fourth is a question assessing confidence. You can use a mix of any of these question types, tailored to your specific topic.

1. **You diagnose your 45 year-old patient with influenza and recall that she has a history of asthma with a recent exacerbation. Based on this patient's medical history, which of the following antivirals should you AVOID due to an increased risk of bronchospasm?**
    1. Baloxavir marboxil (*Xofluza*)
    2. Oseltamivir (*Tamiflu*)
    3. **Zanamivir (*Relenza*)**
    4. Peramivir (*Rapivab*)
    5. All of the above

Rationale: Zanamivir has a manufacturer's warning that it should not be used in patients with underlying airway disease, as it can induce bronchospasm and decline in respiratory function in these patients.

2. **Which of the following is TRUE about treating patients who are high risk for influenza complications?**
    1. **It is recommended to start antiviral treatment even after 48 hours following symptom onset**
    2. Baloxavir marboxil should be avoided because it is not effective in high-risk patients
    3. The CDC recommends prophylactic treatment of high-risk patients with doxycycline to reduce the risk of bacterial co-infection
    4. High-risk patients should be treated with higher doses of antivirals

Rationale: Although antiviral treatment for influenza is most effective when started within 48 hours of symptoms onset, there is evidence of benefit to starting them in high-risk patients even after the 48-hour time window has passed. The CDC recommends initiating antiviral treatment in high-risk patients even after 48 hours have passed since symptoms onset to reduce risk of complications. There is no need for higher doses of antivirals in high risk patients. Although oseltamivir is often used to treat high-risk patients, baloxavir marboxil has shown benefit in high-risk patients and is the only antiviral with an additional FDA indication for treatment of influenza in patients at high risk of influenza-related complications.

3. Which of the following antivirals most rapidly decreases influenza viral load?
    1. Oseltamivir (Tamiflu)
    2. Zanamivir (Relenza)
    3. Peramivir (Rapivab)
    4. **Baloxavir marboxil (Xofluza)**

Rationale: In recent studies, baloxavir marboxil has demonstrated more rapid rates of decline in influenza viral load than the neuraminidase inhibitors (oseltamivir, zanamivir and peramivir) and more rapid decline in viral shedding than oseltamivir and zanamivir. These studies also show that baloxavir's efficacy in reducing flu symptoms is comparable to neuraminidase inhibitors.

4. Please rate your confidence in your ability to [fill in blank]:
    1. Not at all confident

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2. Slightly confident
3. Somewhat confident
4. Fairly Confident
5. Completely confident

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Original Investigation | Medical Education

Assessment of Training in Health Disparities in US Internal Medicine Residency Programs

Denise M. Dupras, MD, PhD; Mark L. Wieland, MD, MPH; Andrew J. Halvorsen, MS; Maria Maldonado, MD; Lisa L. Willett, MD, MACM; Linda Harris

Abstract

IMPORTANCE Health disparities continue to exist despite the call to increase education of health care practitioners. An assessment of health disparities education has not been previously studied in a national cohort.

OBJECTIVE To describe and compare the curriculum on health disparities from the perspective of program directors and perceptions of training among internal medicine residents.

DESIGN, SETTING, AND PARTICIPANTS This cross-sectional survey study used a survey of US internal medicine program directors, the 2015 Association of Program Directors in Internal Medicine annual survey, which included questions about health disparities curriculum, and a 1-time survey of US internal medicine residents that asked questions related to their training in health disparities on the American College of Physicians 2015 Internal Medicine In-Training Examination. All internal medicine program directors who were members of Association of Program Directors in Internal Medicine (368 of 396 accredited programs), and internal medicine residents who took the Internal Medicine In-Training Examination were eligible. Final analysis of the merged data set was completed in 2018.

EXPOSURES Questions were included on the annual Association of Program Directors in Internal Medicine survey and the Internal Medicine In-Training Examination.

MAIN OUTCOMES AND MEASURES Program directors reported on presence of health disparities curriculum, educational methods, quality, barriers and challenges to curriculum, and Clinical Learning Environment Review. Residents reported whether they received training and quality of the training in health disparities.

RESULTS A total of 227 program directors (response rate, 61.7%) and 22 723 residents (response rate, 87.2%) responded to the surveys. A total of 90 program directors (39.6%) reported a curriculum in health disparities, but among these, only 16 program directors (17.8%) felt quality of their education was very good or excellent. In more than half of the programs (52 programs [55.9%]), outcomes of the curriculum were not measured. After merging, the combined data set included 18 883 residents from 366 APDIM member programs with 225 program director responses. Among these, 13 251 residents (70.2%) reported some training in caring for patients at risk for health disparities. Of residents who reported receiving training, 10 494 (79.2%) rated the quality as very good or excellent.

CONCLUSIONS AND RELEVANCE These findings suggest that that despite the Clinical Learning Environment Review mandate and Accreditation Council for Graduate Medical Education required competencies for training in health disparities, relatively few internal medicine programs in the US

(continued)

Key Points

Question Are internal medicine residents being trained to address health disparities, and what are their perceptions of such training?

Findings This survey study of 227 program directors and 22 723 internal medicine residents in training found that residents' perceptions of training in health disparities and its quality were not associated with the presence of a curriculum.

Meaning These findings suggest that adding health disparities curricula in their current forms may not adequately train residents to address gaps in care.

+ Invited Commentary

+ Supplemental content

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Abstract (continued)

provided educational curriculum. Additionally, the existence of health disparities curricula in internal medicine training programs was not associated with resident's perception of training or its quality.

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Introduction

In 2002, the Institute of Medicine, now the National Academy of Medicine, produced their seminal report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare,"[1] which summarized the stark differences in health and health care outcomes between patients in minority groups vs those not in minority groups. Despite significant attention to that report, the 2018 "National Healthcare Disparities Report"[2] found that while some disparities in health care based on race, ethnicity, socioeconomic status, disability, and in populations with special health needs were getting smaller, disparities persisted for poor and uninsured populations in all priority areas. The 2003 report[1] prompted calls for increased education for all health care practitioners (including physicians) to begin to address these disparities.[3,4] This charge is further reflected in the Health Quality Pathways of the Clinical Learning Environment Review (CLER)[5] and required Accreditation Council for Graduate Medical Education (ACGME) competencies. Nevertheless, many trainees do not feel prepared to care for patient populations most at risk for health disparities.[6-8]

While these recommendations have existed for at least a decade,[9] a 2014 review of health care disparities training in residency programs in the US[10] demonstrated few published reports of graduate medical education programs that ensure that residents are competent to address disparities. The first national report of findings for the CLER program,[11] highlighted health disparities as an area of challenge and opportunity for graduate medical education.[12] The major findings were that the primary source of learning involved clinical experiences with patients who were at risk, mainly occurring in primary care settings and was generic, not tailored to the specific populations served by their medical center or hospital. In the second report based on residency site visits, 32.8% of residents and fellows reported their health disparities training was specific to their at-risk populations.[13]

Previous Association of Program Directors in Internal Medicine (APDIM) surveys have addressed some issues related to health disparities, including cultural competency training and quality improvement projects. In the 2012 survey, 16.6% of internal medicine programs reported the presence of a health disparities curriculum. There are studies describing educational curriculum within internal medicine residencies for special populations,[14-17] and a recent survey of internal medicine program directors highlighted disparities related to patients with limited English proficiency in their curricula.[18]

A 2010 multi-institutional study of internal medicine residents' health disparities education[19] found that only 14% of residents surveyed felt confident in their knowledge of underserved populations. However, a 2011 national survey[20] showed that residents' attitudes toward topics regarding medically underserved populations and health disparities were generally favorable. The goals of this study were to describe what internal medicine residency training programs provide as curriculum and/or educational experiences on health disparities, to determine residents' perception of training in health disparities, and to determine the association of program curriculum with resident perception of training.

Methods

The survey study was reviewed and deemed exempt by the Mayo Clinic institutional review board. Program director surveys were granted a waiver of informed consent because data were

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deidentified, per APDIM policy. All residents who completed surveys provided written informed consent. This study is reported in accordance with the American Association for Public Opinion Research (AAPOR) reporting guideline.

Program Director Survey

The APDIM Survey Committee develops and distributes an annual survey to internal medicine program directors to address important issues in graduate medical education. The survey process has been previously described.[21,22] For this study, email notifications with program-specific hyperlinks to a web-based questionnaire were sent in August 2015 to 368 program director members, representing 92.9% of 396 US categorical internal medicine residencies. Reminders were sent to nonresponders biweekly, and personal contact was initiated by committee members in October. The survey closed in November 2015.

The survey collected information on characteristics of the program and program directors, as well as items on health disparities training availability, training content domains, barriers to implementation, and whether the institution had a CLER visit (eAppendix 1 in the Supplement). Survey responses were appended with data from publicly available sources, including the US Census Bureau, the American Medical Association Fellowship and Residency Electronic Interactive Database Access System Online,[23] and the American Board of Internal Medicine.[24] Data from the public ACGME website[25] included accreditation cycle length, government affiliations, number of approved and filled training positions, and program director's appointment date.

Resident Physician Survey

Detailed information concerning the internal medicine In-Training Examination (IM-ITE) resident survey has been reported previously.[26] Briefly, the IM-ITE is a standardized examination developed by a Committee of the American College of Physicians that serves as a self-assessment of medical knowledge for internal medicine residents. Nearly 100% of internal medicine residency programs accredited by the ACGME participate in the IM-ITE, which is administered every August through September. On completion of the IM-ITE, residents are asked to complete a voluntary survey, which is submitted with their online examination. The survey questions are designed to gain an understanding of residents' training environment, and residents are asked for their consent to allow responses to be used in research. The 2015 survey included 3 questions related to a residents' perception of their training in health disparities (eAppendix 2 in the Supplement).

Comparison of Program Director and Resident Responses

Data from the program director and resident surveys were linked by training program via a unique examination identification number for each internal medicine examinee prior to being deidentified to compare program director responses with residents' perceptions of training in health disparities. The inclusion of questions on the APDIM and IM-ITE surveys related to training in health disparities provided a unique opportunity to compare the program director–reported curriculum within their internal medicine training programs with the perceptions and experiences of the residents in training.

Statistical Analysis

Univariate summaries of program director and resident responses were reported as count (with percentage) or mean (with SD), as appropriate. To test the association of resident report of receiving training on health disparities with the proportion of patients considered at-risk whom they cared for, a generalized linear mixed model with a binary response distribution was used to estimate odds ratios. To test the association of PD report of presence of a health disparities curriculum with resident rating of the quality of their training in care for underserved, a generalized linear mixed model with a Gaussian response distribution was used to estimate the mean difference between groups. Both models included random effects to account for nesting of residents within programs. *P* values were

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2-sided, and the threshold for statistical significance was set at $P < .01$ to account for multiple comparisons. Statistical analyses were conducted using SAS statistical software version 9.4 (SAS Institute). Final analysis of the merged data set was completed in 2018.

Results

The program-level data set included 408 training programs, including 396 ACGME internal medicine programs (97.1%), and 368 were APDIM member programs (92.9%), among which 227 program directors (61.7%) responded to the survey. The resident-level data set included 22 723 residents who completed the survey and consented to research use (response rate, 87.2%). After merging, the combined data set included 18 883 residents from 366 APDIM member programs, with 225 program director responses. For analyses requiring identifiably linked PD and resident survey responses, there were 11 583 resident responses available from these 225 responding programs. There were no differences in response rates based on geographical region or program type.

Program Director Survey Results

Most respondents had experienced a CLER visit (160 program directors [71.0%]). Among 66 program directors who had not experienced a CLER visit, 43 (65.1%) expected one in the next 6 months. Only 57 program directors (25.0%) reported that benchmark data on patient diversity or groups at risk for health disparities was disseminated at their institutions. Slightly more than half (127 program directors [56.4%]) reported that some resident quality improvement projects addressed health disparities.

A total of 91 program directors (39.6%) reported a health disparities curriculum. While the mean (SD) time dedicated to the curriculum was 11.4 (20.9) hours, the median (interquartile range) was only 6 (4-10) hours. Nearly all programs included education about racial/ethnic diversity (84 programs [90.3%]) as well as socioeconomic status (84 programs [90.3%]). More than half of programs reported including information about limited English proficiency (54 programs [58.1%]), gender (54 programs [58.1%]), and gender identity/sexual orientation (49 programs [52.7%]). Religious beliefs were addressed in 41 programs (44.1%). Reported educational methods included lectures (66 programs [71.0%]), group discussion (50 programs [53.8%]), and clinical experiences (37 programs [39.8%]). Most program directors rated the quality of their health disparities educations as fair (35 program directors [38.9%]), good (39 program directors [42.4%]), or very good (15 program directors [16.7%]). For most of the programs (52 programs [55.9%]), outcomes of the curriculum were not measured. Assessment of the curriculum included direct observation of residents (33 programs [35.5%]), but more rarely clinical outcomes (9 programs [9.7%]), resident attitudes (8 programs [8.6%]), or knowledge (8 programs [8.6%]).

Among 132 programs that did not have a curriculum, barriers to development included time within the current curriculum (reported by 64 program directors [48.5%]), insufficient faculty skill (reported by 63 program directors [47.7%]), lack of institutional support (reported by 42 program directors [31.8%]) and lack of faculty interest (reported by 29 program directors [22.0%]). Only 40 program directors (30.5%) intended to develop and implement a curriculum within 1 year; 40 program directors (30.5%) had no plans for a curriculum, and 51 program directors (38.9%) were unsure.

Resident Survey Results

The 18 883 resident survey responses were similarly distributed across the 3 years of training, with 6403 residents (33.9%) in postgraduate year 1, 6571 residents (34.8%) in postgraduate year 2, and 5909 (31.3%) in postgraduate year 3. Overall, 13 251 residents (70.2%) reported some training in caring for patients at risk for health disparities. This percentage did not differ significantly based on geographic location of training. The perception of receiving training increased with each additional postgraduate year.

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Among 13 251 residents who reported training, more than three-quarters (10 294 residents [77.7%]) rated the quality of this training as being very good (5503 residents [41.5%]) or excellent (4791 residents [36.2%]) (**Table 1**). There was an association between a resident's perceived receipt of training and their estimated proportion of patients who would be considered at risk for health disparities (**Table 2**).

Comparison of Program Director and Resident Responses

While less than 40% of program directors reported a curriculum for training in health disparities, most residents reported training in the care of patients who are at risk for health disparities (ie, those who are underserved, uninsured, unemployed, or experiencing homelessness). We observed no association between the program director–reported presence of a curriculum and the resident report of training or their rated quality of their training in the merged data set of 225 program director responses matched with 11 583 resident responses (**Table 3**).

Discussion

This survey study is the first to our knowledge to report on the breadth of health disparities training within internal medicine training programs in the US. While approximately 70% of program directors reported a CLER visit, suggesting awareness of the requirement for health disparities training, only 40% of program directors reported having a curriculum. The curriculum was often limited to a few hours and lecture-based, which may not effectively engage learners. There was limited assessment of the impact of the curriculum on outcomes for the learner or the patients they care for. Only 30% of

Table 1. Program Director and Resident Rating of Training in Health Disparities

	No. (%)	
Rating	Program directors (n = 90)	Residents (n = 13 251)
Poor	2 (2.2)	47 (0.4)
Fair	35 (38.9)	524 (4.0)
Good	39 (42.4)	2386 (18.0)
Very good	15 (16.7)	5503 (41.5)
Excellent	1 (1.1)	4791 (36.2)

Table 2. Association of Resident Perception of Health Disparities Training With Proportion of Underserved Patients in Their Practice

Perceived underserved patients treated, %	Residents reporting training (n = 18 883)	
	Odds ratio (99% CI)	*P* value
<10	1 [Reference]	
10-25	1.34 (1.10-1.64)	<.001
26-50	1.74 (1.42-2.13)	<.001
51-75	2.02 (1.64-2.48)	<.001
>75	2.31 (1.86-2.87)	<.001
Not sure	0.97 (0.78-1.21)	.69

Table 3. Association of Program Director–Reported Health Disparities Curriculum and Resident's Perception of Quality of Disparities-Related Training

		Resident rating of training, No. (%)						
Presence of curriculum	Programs, No.	Excellent	Very good	Good	Fair	Poor	No training	Totals
Yes	91	1462 (27.1)	1683 (31.2)	620 (11.5)	145 (2.6)	13 (0.2)	1479 (27.3)	5402 (28.6)
No	133	1450 (23.6)	1742 (28.3)	769 (12.5)	159 (2.6)	10 (0.2)	2008 (32.7)	6138 (32.5)
No response	142	1879 (25.6)	2078 (28.3)	997 (13.6)	220 (3.0)	24 (0.3)	2145 (29.2)	7343 (38.9)
Total	366	4791 (25.4)	5503 (29.1)	2386 (12.6)	524 (2.8)	47 (0.2)	5632 (29.8)	18 883

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internal medicine programs without a current curriculum planned to address this need within the next year. While this was an improvement over the 2012 survey, in which only 16.6% of programs reported a curriculum, our findings raise concerns that additional efforts are needed for internal medicine graduate medical education to increase health disparities curricula.

Challenges to developing curriculum were identified by program directors, most significantly competing curricular priorities. There was the additional challenge of determining what a health disparities curriculum should contain (eg, cultural competency, health disparities, health inequities, social determinants of health). Unlike undergraduate medical education, time for authentic community engagement is limited during graduate medical education. This leaves didactic curricula (eg, lectures, online modules) and quality improvement work as the primary educational activities. Didactic curriculum, while efficient, does not fully foster understanding of the lived experience of health inequities nor foster cultural humility. Results of this study suggest that quality improvement initiatives aimed at reduction of practice-based health disparities are hampered by lack of access to data, that is, only 25% of program directors reported access to data that stratify according to different populations. Indeed, most published reports of curricular innovations in health disparities education in residency focus on educational outcomes rather than improvement in patient outcomes.[27-30]

To our knowledge there are no prior studies that have reported results from a national survey of internal medicine resident perceptions on training in health disparities. Overall, 70% of residents reported training. Residents who cared for a larger proportion of underserved patients perceived that they received health disparities training at a higher rate. Since an essential component of graduate medical education is direct patient care and academic medical centers provide care for a disproportionate proportion of underserved populations in the US,[31] this may provide an opportunity for meaningful learning in the context of graduate medical education. Point of care teaching around health disparities and social determinants of health can be a powerful mechanism for residents to internalize these complex topics through the eyes of their own patients.[32] A comment on the program director survey summarized this practice: "...we take care of the patients in our community with health care disparities. We live it every day!" However, reliance on learning in the context of caring for patients who are underserved does not ensure residents will receive the training and acquire the skills they will need. Accordingly, a 2019 study found that increased care of at-risk populations did not translate into increased relevant knowledge among resident physicians.[33] Additionally, while some data suggest a positive influence of care of underserved populations on the attitudes of residents, there was no improvement in patient care with additional training and an inverse association was found between self-reported skills and knowledge.[34] Our finding that residents' rating of the quality of their training was not associated with the presence of a curriculum in health disparities in their program also raises a concern that perceptions may overestimate the acquisition of needed skills.

Strengths of this study include a large, representative, and comprehensive sample of all internal medicine residents and program directors in the US with high survey response rates. Furthermore, the ability to link responses of residents with their programs through coincident surveys in the same calendar year provided a powerful tool for comparison of resident perceptions and curriculum.

Limitations

The study has limitations. A major limitation was that residents were not asked directly if they were exposed to a curriculum in health disparities but rather if they received training in the care of patients who would be at risk, which raises the concern that we cannot distinguish between their recognition of a formal and informal curriculum. Additionally, while program directors were asked explicitly whether they had a curriculum, we cannot know with certainty that they were aware of all training, but given their reporting responsibilities, we feel it is a reasonable assumption. Furthermore, because the survey items were embedded in larger program director survey, we were limited in the ability to ask them to define more specifically the components of their health disparities curricula.

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Conclusions

This survey study found that the existence of health disparities curricula among internal medicine residency programs were below goal levels established by national accrediting bodies and that existing curricula were not associated with resident's perception of training in these domains. Residents who cared for more patients who are underserved reported higher disparities training despite a lack of formal curricula, highlighting the opportunity to teach around health disparities at the point of care, but also the need for standardized curriculum and capable faculty. Additionally, program directors reported a lack of practice-level data to examine health disparities, which emphasizes the opportunity for institutional collaboration with residency programs for quality improvement initiatives aimed at the reduction of health disparities.

Future research is needed to develop and assess the most relevant domains for health disparities curricula in graduate medical education, including for point-of-care encounters and quality improvement. There are opportunities to explore partnerships among residencies, institutional clinical practices, and communities for productive collaborations around disparities-related quality improvement projects to address gaps in health care that are specific to the populations they serve.

ARTICLE INFORMATION

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Corresponding Author: Denise M. Dupras, MD, PhD, Mayo Clinic College of Medicine and Science, 200 First Ave SW, Rochester, MN 55905 (dupras.denise@mayo.edu).

Author Affiliations: Mayo Clinic College of Medicine and Science, Rochester, Minnesota (Dupras, Wieland, Halvorsen); Icahn School of Medicine at Mount Sinai, Yonkers, New York (Maldonado); University of Alabama School of Medicine, Birmingham (Willett); Research Center, American College of Physicians, Philadelphia, Pennsylvania (Harris).

Author Contributions: Dr Dupras and Mr Halvorsen had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Dupras, Wieland, Halvorsen, Maldonado.

Acquisition, analysis, or interpretation of data: Dupras, Halvorsen, Willett, Harris.

Drafting of the manuscript: Dupras, Wieland, Halvorsen, Maldonado.

Critical revision of the manuscript for important intellectual content: All authors.

Statistical analysis: Halvorsen.

Administrative, technical, or material support: Wieland, Halvorsen, Willett, Harris.

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SUPPLEMENT.

eAppendix 1. Association of Program Directors in Internal Medicine 2015 Annual Survey

eAppendix 2. Questions on the 2015 Internal Medicine American College of Physicians In-Training Examination

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, May 29, 2023 9:53 AM PDT
To: [redacted]@uthsc.edu>
CC: [redacted]@ucsf.edu>; Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: Opportunities for away rotation

Hi [redacted],

The UCSF Child and Adolescent Gender Center (CAGC), itself, doesn't directly host visiting residents. However, the CAGC is housed within the division of pediatric endocrinology, and visiting residents that do an elective in pediatric endocrinology would have access to the CAGC clinics, which currently meet two half-days per week. I have cc'd [redacted], UCSF Program Director for Pediatric Endocrinology, who can advise you about an elective. You expressed an interest in both adolescent and adult gender-affirming care, so I have also cc'd Dr. Maddie Deutsch, Director of the adult gender program at UCSF.

Best wishes,

Steve Rosenthal

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@uthsc.edu>
Sent: Thursday, May 25, 2023 1:01 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Opportunities for away rotation

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Hi Dr. Rosenthal,

My name is [redacted] and I'm a third-year med peds resident at the University of Tennessee in Memphis, TN. One of my clinical interests is gender-affirming care, and due to restrictive legislation, we have very limited opportunities in Memphis to train in adult gender-affirming care and none in pediatrics. Ideally, I would like to become more familiar with both adolescent and adult populations. My program director has told me that I would be able to schedule a three-week away rotation this upcoming academic year in order to receive this training. One of his adolescent medicine colleagues recommended that I look into UCSF. Does the UCSF Child and Adolescent Gender Center have any opportunities for hosting visiting residents? I appreciate any help!

Best,
[redacted]

[redacted]
Resident Physician, PGY-3

The University of Tennessee Health Science Center
Internal Medicine - Pediatrics
920 Madison Ave, Room 551
Memphis, TN 38163

[redacted]
[redacted]

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'Confusing and difficult': Transgender patients try to navigate maze of Medicaid coverage

Coverage for gender-affirming care under for-income American coverage varies from state to state.

Erin Durkin @ERINDURKIN
5 minutes ago

Transgender and gender-diverse Marylanders on Medicaid, access to affirming services will expand in the upcoming months. While the state's Medicaid program already covered some care, first-year Gov. Wes Moore on May 3 signed a bill into law expanding coverage to ensure it's more extensively excluded, such as facial feminization surgery.

Florida, meanwhile, is heading in the opposite direction. The Sunshine State is banning gender-affirming services covered by Medicaid as Gov. Ron DeSantis wages a very public battle against what he calls "woke" culture.

The recent actions by both states show just how much Medicaid coverage of gender-affirming care ranges across the United States. And within a single state, even a supportive state like Maryland, there can still be barriers to access. The addition of facial-feminization surgery as a covered service, for example, is a big deal, said C.T. Hoffman, senior policy counsel at the National Center for Transgender Equality.

It's a huge benefit for folks who have a lot of intense dysphoria about their bodies feel that their face looks very masculine; this is the thing that is most helpful to them in order to deal with that dysphoria because it's literally the thing that you see in the mirror all the time," Hoffman said. "That's a huge, huge benefit for those people."

The new law, which goes into effect on Jan. 1, 2024, is also limited in a couple ways. "In theory this should provide a lot of protection for patients, but there are issues," Hoffman said. "I know that there's a lot of folks in Maryland and at the national organizations that are going to be watching how the rollout actually works."

The patchwork of rules and coverage limits presents a daunting set of options for patients and providers confronting a life-changing event that often carries the added burden of societal disapproval.

On top of navigating the varying coverage policies, transgender and gender-diverse individuals are also going through the redetermination process impacting all patients on the program. States had frozen disenrollments during the COVID-19 pandemic in exchange for a bump in federal funding, but they've been in the process of unwinding these policies since April.

New KFF data from 11 states showed that already more than half a million beneficiaries have been disenrolled from Medicaid, with March taking the lead at 620,000 beneficiaries disenrolled.

Another report released this week from the Center for Popular Democracy, Make the Road New York (MRNY), and People's Action Institute surveyed beneficiaries' experiences with the Medicaid program. The report showed that Black, Latino and Indigenous beneficiaries were the least likely to report that they received help in applying for Medicaid. They were also more likely to report facing challenges accessing their benefits.

"Medicaid is a very important program for transgender people, period, and it has its most significant Medicaid coverage for transgender people even to access Medicaid for any type of care," said Kellan Baker, executive director and chief learning officer at the Whitman-Walker Institute in Washington.

2023
Trans kids struggle with mental health during political firestorm

A lot of times, that's about whether gender-affirming care should be recognized as appropriate and nondiscriminatory, or whether it's medically necessary," said ERIN DUNKIN

Baker said that a lot of Medicaid re-eligibility redetermination processes are designed in a way that is find and match the right information in different systems to establish a person's eligibility.

"If a transgender person does not have all of their ID updated because they haven't had the chance to do it — because, let's say, a state law does not allow that, or they have updated their records in some systems but not in others — they're likely to have a very tough time with a dragnet of states seeking to kick people off of their Medicaid rules as quickly as possible is quite high," he said.

A December 2022 report from UCLA's Williams Institute estimated that, of 1.3 million transgender adults living in the U.S., 276,000 (21%) were enrolled in Medicaid. Research shows that access to care with policies that expressly covered gender-affirming care, including Medicaid, was associated in states that were silent or unclear about their policies, and 14 percent fewer adults with Medicaid coverage.

Even in states that don't definitively say whether Medicaid will cover or exclude the services, patients are finding care, said Christy Mallory, legal director of the Williams Institute, who researched the report. "It still can be a burden on folks as they try to navigate the system, and sometimes it's confusing and difficult for anyone," Mallory said.

The report also noted that some courts have ruled that exclusions of gender-affirming care under Medicaid are a violation of the Affordable Care Act, which provides protections against discrimination on the basis of sex in health programs.

Those protections are in place, so Medicaid coverage are subject to a court challenge. The state's health department last year adopted regulations banning discrimination against LGBTQ patients. Earlier this year DeSantis signed into law last month a prohibition on state funds being used for gender-affirming services.

The new law preempted the rule, and the report says that the ban on coverage violates the Constitution, protections under the ACA, and Medicaid's equity requirements. The two-week trial ended on May 22 and judgment is still pending.

But there could also be barriers in states that do explicitly cover gender-affirming care. Mississippi, where the Medicaid program does explicitly cover gender-affirming services, advocates are still working to fill in coverage gaps. There are gender-response exclusions, such as for gender enhancement and implants of the calf or pectoral, said Andrew Cohen, director of the Access to Care and Innovation Hub at the Center for Health Law.

"To have a blanket exclusion of these types of implants is inappropriate because every situation is different, every body is different, the need is different," Cohen said. "Those kinds of blanket exclusions are inappropriate and should be revisited."

Additionally, current requirements for multiple referrals prior to getting gender-affirming surgeries do not align with guidance from the World Professional Association for Transgender Health, he noted.

The guidelines in Massachusetts require two letters from different providers that have diagnosed the patient with gender dysphoria. But a patient can receive certain gender-affirming surgeries. The recommendations, however, sometimes require only one letter for surgeries if documentation is needed.

"It is absolutely a barrier for people to get multiple letters from providers," Cohen said, adding that it could also be hard because some providers charge patients for the letters.

Madeline Deutsch, president of the US Professional Association for Transgender Health, said there are still a lot of purses making requirements based on older recommendations. "That might be requiring two letters from providers, that might be requiring two letters at all, and that's just not up to date," Deutsch said.

Deutsch added that other surgical procedures require pre-operation evaluations. "Like all medical care, the approach to providing this care is very intentional and very appropriately appropriately carefully as it would be for any other surgical intervention," she said.

Dallas Ducar, founding CEO of the health care center Transhealth in Massachusetts, suggested that letter requirements for accessing care should not be necessary.

"As a trans individual who is able to have my own informed consent and make medical decisions, I still do question why we require a letter for adults" for gender-affirming surgeries, Ducar said. "I do think that is still something of gatekeeping that we do, because it's more difficult to be able to access any type of mental health provider."

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From: Transgender Care Navigation Program <TransCare@ucsf.edu>
Sent: Wednesday, June 07, 2023 9:30 AM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: FW: Gender Affirming Top/Chest Surgery Visual Aids

Hi Maddie,

Please see email below.

Thank you,

[redacted] M.A.
Patient Navigator III
UCSF Gender Affirming Health Program
Phone: (415)885-3577
Fax: (415)353-3399
http://transcare.ucsf.edu/
Pronouns: she/her/hers

From: [redacted]@umich.edu>
Sent: Wednesday, June 7, 2023 4:58 AM
To: Transgender Care Navigation Program <TransCare@ucsf.edu>
Subject: Gender Affirming Top/Chest Surgery Visual Aids

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Good morning,

My name is [redacted] and I'm currently a graduate student at the University of Michigan, in the Genetic Counseling program. I'm currently working at a cancer genetics clinic, and part of what I do is talk to patients about what genetic testing could mean for them and their cancer treatment and management (both now and for the future). I use visual aids to explain complex genetics topics so that patients can truly provide autonomous, informed consent to testing.

I'm reaching out because there are very few resources or visual aids for trans and non-binary patients in the cancer space. I'm curious if there are resources that you might be willing to share with me about gender affirming top/chest surgery. Since a mastectomy and gender affirming chest surgery have very different outcomes in terms of the preservation and removal of chest tissue, it's important to be able to share this difference with patients. Instead of creating something myself that may or may not accurately depict gender affirming chest/top surgery, I'm hoping that I might call upon resources like you at UCSF who may have more accurate, effective, and appropriate visuals and resources to share with patients who are thinking about the possibility of having chest tissue removed.

I'd appreciate anything that you'd be willing to share with me.

Warm regards,
[redacted]

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From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, June 12, 2023 10:08 PM PDT
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds? - Your Info Needed
Attachment(s): "Headshot 2023.JPG"

Hi [redacted] headshot attached.

Title - Caring for Trans and Gender Diverse People - Evidence Based Medicine Across the Lifespan

Summary - Trans and Gender Diverse People need access to quality healthcare. This "Gender Affirming Care" can include medical or surgical care to align one's body with their identified gender, as well as access to a full scope of medical care that is respectful and culturally grounded, and acknowledges gender identities as valid. Recent political developments have added an additional layer of complexity to the barriers to care and disparities faced by this vulnerable population. In this talk, Dr. Deutsch will review current evidence in selected areas of gender affirming care for children, adolescents, and adults of all ages.

Bio - Maddie Deutsch, MD, MPH is a Professor of Clinical Family & Community Medicine at UCSF, and the founding Medical Director for the UCSF Gender Affirming Health Program, a multidisciplinary group of medicine, surgical, and behavioral health providers for trans and gender expansive adults at UCSF Health. She is a Co-Director for the UCSF School of Medicine Differences Matter Initiative, and a DEIB Co-Lead for UCSF Health. Dr. Deutsch has authored or co-authored more than 50 peer reviewed journal articles in the field of sexual and gender minority health, and was a co-author, and Primary Care Chapter Lead, for the recently released WPATH Standards of Care, 8th Version. She is the current President of the US Professional Association for Transgender Health.

Cheers,

Maddie

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, June 12, 2023 11:05 AM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds? - Your Info Needed

Sorry [redacted] I've been really overwhelmed and was on PTO last week. I will get you that by today!

From: [redacted]@ucsf.edu>
Sent: Monday, June 12, 2023 10:54 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds? - Your Info Needed

It would be great to get the info for your upcoming FCM Grand Rounds posted on the FCM website. Can you send me the info requested below?

Thanks.

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu |https://fcm.ucsf.edu/

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From: [redacted]
Sent: Friday, June 2, 2023 5:01 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Hi Maddie,

I'm checking back with you about the info requested below.

Please send me your photo, bio, a title for your presentation, and a brief (paragraph) summary of your presentation.

Thanks.

[redacted]

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[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu |https://fcm.ucsf.edu/

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, November 21, 2022 1:09 PM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Great, thank you!

From: [redacted]@ucsf.edu>
Sent: Monday, November 21, 2022 12:37 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Great. Thanks, Maddie. You are confirmed for July 7, 2023. Here are some additional details:

About 4-5 weeks out, please send me your photo, bio, a title for your presentation, and a brief (paragraph) summary of your presentation. This will allow me to update our website with your upcoming presentation info and also give me what I need to send out our email invite to our broadcast list. I typically send the email about 3-4 weeks prior and then follow it up with a reminder the week of. Here's where we post the info so you can get a sense of what I'll need: https://fcm.ucsf.edu/family-community-medicine-grand-rounds

Please also send me your presentation materials (slides) a day or two before your event. I put these in a Box folder in case something goes wrong with your screen sharing the day of the presentation. This allows our tech expert, who will be on the webinar, what he'll need to jump in, if necessary.

Also, during the early part of the week of your presentation I will be sending you a specialized individual link for you to use to get on the webinar. This link is different than the generalized link to participants and will allow you to be visible during the webinar. This particular email will come from [redacted]@ucsf.edu as this is the email I use to manage the event. Please make sure to check that it doesn't get captured in any spam folders you may have.

Lastly, we ask presenters to use the specialized link to get on the webinar at 11:30am, 30 minutes prior to start time. This is a time to test your camera, sound, screen share, etc. and tee things up for a successful presentation. Our tech expert will be on the call at that time to iron out any bugs and answer questions. You'll just stay with that same link for when the webinar actually begins at noon.

If you have any questions or concerns, just let me know. We look forward to your upcoming presentation on July 7, 2023.

Thanks.

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu |https://fcm.ucsf.edu/

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, November 21, 2022 12:34 PM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Hi [redacted] let's do July 7. Please let me know when confirmed.

Thanks,

Maddie

From: [redacted]@ucsf.edu>
Sent: Monday, November 21, 2022 10:05 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

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Hi Maddie,

For 2023 we have the following dates open:

January 6, 2023
July 7, 2023
August 4, 2023

If none of these work, we'd be moving into 2024. Do any of the above dates work?

Thanks.

[redacted]

[redacted]M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: [redacted]
Sent: Thursday, November 17, 2022 2:58 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Hi Maddie,

I'm waiting to hear back from two people about confirming dates, so once I hear back from them I'll let you know what is available. Thanks.

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: [redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 12:37 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Huge thanks, Maddie! I am eager to hear your presentation.
Happy Thanksgiving -
[redacted]

[redacted]MD, MPH
Assistant Dean, Undergraduate Medical Education at UC Merced (interim)
Vice Chair of Education, UCSF Department of Family Medicine
Endowed Chair in Community Medicine, Vitamin Settlement Fund
Professor of Clinical Family and Community Medicine
University of California, San Francisco
[redacted]@ucsf.edu

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, November 17, 2022 12:23 PM
To: [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Hi [redacted], thanks for the invite, and I am sorry for my delayed reply. I'd be delighted to speak at FCM Grand Rounds. [redacted] please let me know what dates will work. Probably best to look at Feb and beyond.

Cheers,

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Maddie

From: [redacted]@ucsf.edu>
Sent: Friday, November 11, 2022 4:33 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Present at UCSF FCM Grand Rounds?

Hi Maddie,
Would you be willing to give FCM Grand Rounds on the role of primary care clinicians in gender affirming care, or gender affirming care in the public health setting, or any related topic that you feel would be a better fit?

As you know, FCM GR focus on themes of health equity and social justice. Your work in gender affirming care seems like it a terrific fit for GR and would be of tremendous interest to our audience, which includes DFCM, 10 affiliated FCM residency sites, DPH primary care, and more.

GR is the first Friday of the month from 12-1pm by zoom. We are scheduling up to a year in advance. Here is a link to recent sessions.
https://fcm.ucsf.edu/family-community-medicine-grand-rounds

If you are willing to present, I will cc [redacted] who can help find a time that works for you.

I hope you are doing well. Thanks for considering!

[redacted]

[redacted] MD, MPH
Assistant Dean, Undergraduate Medical Education at UC Merced (interim)
Vice Chair of Education, UCSF Department of Family Medicine
Endowed Chair in Community Medicine, Vitamin Settlement Fund
Professor of Clinical Family and Community Medicine
University of California, San Francisco
[redacted]@ucsf.edu

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From: [redacted]@ucsf.edu>
Sent: Tuesday, June 13, 2023 11:59 AM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds? - Your Info Needed

Perfect. Thanks, Maddie. I just posted it to the FCM website:https://fcm.ucsf.edu/family-community-medicine-grand-rounds

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, June 12, 2023 10:08 PM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds? - Your Info Needed

Hi [redacted] headshot attached.

Title - Caring for Trans and Gender Diverse People - Evidence Based Medicine Across the Lifespan

Summary - Trans and Gender Diverse People need access to quality healthcare. This "Gender Affirming Care" can include medical or surgical care to align one's body with their identified gender, as well as access to a full scope of medical care that is respectful and culturally grounded, and acknowledges gender identities as valid. Recent political developments have added an additional layer of complexity to the barriers to care and disparities faced by this vulnerable population. In this talk, Dr. Deutsch will review current evidence in selected areas of gender affirming care for children, adolescents, and adults of all ages.

Bio - Maddie Deutsch, MD, MPH is a Professor of Clinical Family & Community Medicine at UCSF, and the founding Medical Director for the UCSF Gender Affirming Health Program, a multidisciplinary group of medicine, surgical, and behavioral health providers for trans and gender expansive adults at UCSF Health. She is a Co-Director for the UCSF School of Medicine Differences Matter Initiative, and a DEIB Co-Lead for UCSF Health. Dr. Deutsch has authored or co-authored more than 50 peer reviewed journal articles in the field of sexual and gender minority health, and was a co-author, and Primary Care Chapter Lead, for the recently released WPATH Standards of Care, 8th Version. She is the current President of the US Professional Association for Transgender Health.

Cheers,

Maddie

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Subject: Re: Present at UCSF FCM Grand Rounds? - Your Info Needed

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[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
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From: [redacted]
Sent: Friday, June 2, 2023 5:01 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Hi Maddie,

I'm checking back with you about the info requested below.

Please send me your photo, bio, a title for your presentation, and a brief (paragraph) summary of your presentation.

Thanks.

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, November 21, 2022 1:09 PM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Great, thank you!

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Sent: Monday, November 21, 2022 12:37 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Great. Thanks, Maddie. You are confirmed for July 7, 2023. Here are some additional details:

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Lastly, we ask presenters to use the specialized link to get on the webinar at 11:30am, 30 minutes prior to start time. This is a time to test your camera, sound, screen share, etc. and tee things up for a successful presentation. Our tech expert will be on the call at that time to iron out any bugs and answer questions. You'll just stay with that same link for when the webinar actually begins at noon.

If you have any questions or concerns, just let me know. We look forward to your upcoming presentation on July 7, 2023.

Thanks.

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Sent: Monday, November 21, 2022 12:34 PM
To: J[redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Hi [redacted] let's do July 7. Please let me know when confirmed.

Thanks,

Maddie

From: [redacted]@ucsf.edu>
Sent: Monday, November 21, 2022 10:05 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Hi Maddie,

For 2023 we have the following dates open:

January 6, 2023
July 7, 2023
August 4, 2023

If none of these work, we'd be moving into 2024. Do any of the above dates work?

Thanks.

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
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From: [redacted]
Sent: Thursday, November 17, 2022 2:58 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Hi Maddie,

I'm waiting to hear back from two people about confirming dates, so once I hear back from them I'll let you know what is available.
Thanks.

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
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From: [redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 12:37 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Huge thanks, Maddie! I am eager to hear your presentation.
Happy Thanksgiving -
[redacted]

[redacted] MD, MPH
Assistant Dean, Undergraduate Medical Education at UC Merced (interim)
Vice Chair of Education, UCSF Department of Family Medicine
Endowed Chair in Community Medicine, Vitamin Settlement Fund
Professor of Clinical Family and Community Medicine
University of California, San Francisco
[redacted]@ucsf.edu

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, November 17, 2022 12:23 PM
To: [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Hi [redacted] thanks for the invite, and I am sorry for my delayed reply. I'd be delighted to speak at FCM Grand Rounds. [redacted] please let me know what dates will work. Probably best to look at Feb and beyond.

Cheers,

Maddie

From: [redacted]@ucsf.edu>
Sent: Friday, November 11, 2022 4:33 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Present at UCSF FCM Grand Rounds?

Hi Maddie,
Would you be willing to give FCM Grand Rounds on the role of primary care clinicians in gender affirming care, or gender affirming care in the public health setting, or any related topic that you feel would be a better fit?

As you know, FCM GR focus on themes of health equity and social justice. Your work in gender affirming care seems like it a terrific fit for GR and would be of tremendous interest to our audience, which includes DFCM, 10 affiliated FCM residency sites, DPH primary care, and more.

GR is the first Friday of the month from 12-1pm by zoom. We are scheduling up to a year in advance. Here is a link to recent sessions.
https://fcm.ucsf.edu/family-community-medicine-grand-rounds

If you are willing to present, I will cc [redacted] who can help find a time that works for you.

I hope you are doing well. Thanks for considering!

[redacted]

[redacted], MD, MPH
Assistant Dean, Undergraduate Medical Education at UC Merced (interim)
Vice Chair of Education, UCSF Department of Family Medicine
Endowed Chair in Community Medicine, Vitamin Settlement Fund
Professor of Clinical Family and Community Medicine
University of California, San Francisco
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From: [redacted]@ucsf.edu>
Sent: Tuesday, June 13, 2023 12:18 PM PDT
To: [redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: UCSF FCM Grand Rounds - Caring for Trans and Gender Diverse People - Evidence Based Medicine Across the Lifespan - with Dr. Maddie Deutsch - Friday, July 7 at noon

UCSF FCM Grand Rounds

Caring for Trans and Gender Diverse People - Evidence Based Medicine Across the Lifespan

Friday, July 7, 2023
12:00-12:50pm by webinar

https://ucsf.zoom.u[redacted]

Maddie Deutsch, MD, MPH

Trans and Gender Diverse People need access to quality healthcare. This "Gender Affirming Care" can include medical or surgical care to align one's body with their identified gender, as well as access to a full scope of medical care that is respectful and culturally grounded, and acknowledges gender identities as valid. Recent political developments have added an additional layer of complexity to the barriers to care and disparities faced by this vulnerable population. In this talk, Dr. Deutsch will review current evidence in selected areas of gender affirming care for children, adolescents, and adults of all ages.

Maddie Deutsch, MD, MPH is a Professor of Clinical Family & Community Medicine at UCSF, and the founding Medical Director for the UCSF Gender Affirming Health Program, a multidisciplinary group of medicine, surgical, and behavioral health providers for trans and gender expansive adults at UCSF Health. She is a Co-Director for the UCSF School of Medicine Differences Matter Initiative, and a DEIB Co-Lead for UCSF Health. Dr. Deutsch has authored or co-authored more than 50 peer reviewed journal articles in the field of sexual and gender minority health, and was a co-author, and Primary Care Chapter Lead, for the recently released WPATH Standards of Care, 8th Version. She is the current President of the US Professional Association for Transgender Health.

Join by webinar:
Friday, July 7, 2023 from noon-12:50pm
https://ucsf.zoom.us/j/[redacted]
Webinar ID: [redacted]
Passcode: [redacted]

Thanks to everyone who joined us for prior FCMGrand Rounds in 2021-2023!

June 2, 2023 – Dr. Kevin Fiscella -Why Defining Health Is Radical: Implications for Health Equity, Value, and National Health

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May 5, 2023 – Dr. Martin Shapiro - The Present Illness: American Health Care and Its Intractable Afflictions
April 7, 2023 – Dr. Megan Mahoney – Demoralization in Medicine with a Focus on Strategies and Solutions
March 3, 2023 – Dr. Michael Fine - What is Medicine For? - Reflections from On Medicine as Colonialism
February 3, 2023 – Dr. Hillary Kunins -San Francisco's Approach to Improving Behavioral Health Services
December 2, 2022 – Dr. Kevin Grumbach, Pilar Collins & Tasha Toliver - An Equity First Paradigm for Health Care: Hard Earned Lessons from the UCSF Health Response to COVID
November 4, 2022 - Ana Delgado, Ji Seon Song, Nida Bajwa, Norman Archer, Jake Sonnenberg, Kelley Butler -Safety for All and Care without Criminalization: A DPH Must Divest Intro to Patient Rights
October 7, 2022 – Dr. Meghan O'Brien - From Eggshells to Action: Preparing to Address Microaggressions Targeting Learners
September 2, 2022 – Dr. Ayanna Bennett – "Moving from Intention to Action on Health Equity"
June 3, 2022 – Daniel Dawes, J.D. – "The Political Determinants of Health: Advocating for Equitable Health Outcomes"
May 6, 2022 – Dr. Maura Jones, Dr. Deb Borne, & Dr. Jack [redacted] – "Anti-coercion Ethics and the Avoidance of Medical Harm: A Case-based Discussion"
April 1, 2022 - Dr. Ron Goldschmidt, Brenda Goldhammer, Dr. Betty Dong, Dr. Christine Pecci, Dr. Carolyn Chu – "The National Clinician Consultation Center: 30 years (and counting) of tele-consultation for provider capacity-building and public health service"
March 4, 2022 - Nazineen Kandahari & Nilufar Kayhani – "Afghan Clinic: Barriers to Health for Afghan Refugees & How We Can Address Them"
February 4, 2022 – Dr. Christine Dehlendorf, Dr. Lealah Pollock, & Dr. Montida Fleming – "Family Medicine and Abortion: Responding to the Evolving Crisis in Access to Reproductive Health Care"
January 7, 2022 – Dr. Garen Wintemute – "Firearm Violence: Where We Stand, What We Can Do"
December 3, 2021 – Dr. Shira Shavit & Joe Calderon, CHW – "Who We Hire Matters: How Health Systems Address Structural Racism Through Hiring People with Histories of Incarceration"
November 5, 2021 – Dr. Saul Weiner – "Contextualizing Care: An Essential and Measurable Clinical Competency"
October 1, 2021 – Dr. Emilia De Marchis, Dr. Matt Pantell, & Dr. Caroline Fichtenberg – "Should we screen for and document social risk in health care settings?"
September 3, 2021 – Dr. Sundeep Gupta & Professor AddressMauakowa Malata, PhD – "Redefining Global Health through Structural Competency and Allyship"
August 6, 2021 – Dr. Tricia Elliott – "Addressing Racism and Advancing Health Equity In and Beyond the Exam Room"
June 4, 2021 – Dr. Ina Park – "*Strange Bedfellows: Adventures in the Science, History, and Surprising Secrets of STDs.*"
May 7, 2021 – Dr. Rita Hamad -"Social Policies to Address Health Inequities: Harder Than It Looks"
April 2, 2021 - UCSF faculty, staff, and community partners - STOP COVID-19 CA Project- "Achieving Racial and Ethnic Equity in COVID-19 Vaccination: Learnings from Community Based Participatory Research."
March 5, 2021 - Dr. Kevin Grumbach and Dr. Juliana Morris - "*The Lancet Commission: Health and Health Policy in the Trump Administration*"

Did you miss them?
Watch most session recordings in our playlist:
[redacted]

Want to share your feedback?
Please fill out an evaluation:
[redacted]

Have suggestions for future FCM Grand Rounds topics or speakers?
Please share your ideas:
[redacted]

Hope you can join us on July 7th!

[redacted]

[redacted]MD, MPH
Assistant Dean, Undergraduate Medical Education at UC Merced (interim)
Vice Chair of Education, UCSF Department of Family Medicine
Endowed Chair in Community Medicine, Vitamin Settlement Fund
Professor of Clinical Family and Community Medicine
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Roy Johnston, M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
Roy.Johnston@ucsf.edu | https://fcm.ucsf.edu/

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From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Wednesday, June 14, 2023 11:57 AM PDT
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds? - Your Info Needed

Thank you!

From: [redacted]@ucsf.edu>
Sent: Tuesday, June 13, 2023 11:59 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds? - Your Info Needed

Perfect. Thanks, Maddie. I just posted it to the FCM websitehttps://fcm.ucsf.edu/family-community-medicine-grand-rounds

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu |https://fcm.ucsf.edu/

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, June 12, 2023 10:08 PM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds? - Your Info Needed

Hi [redacted] headshot attached.

Title - Caring for Trans and Gender Diverse People - Evidence Based Medicine Across the Lifespan

Summary - Trans and Gender Diverse People need access to quality healthcare. This "Gender Affirming Care" can include medical or surgical care to align one's body with their identified gender, as well as access to a full scope of medical care that is respectful and culturally grounded, and acknowledges gender identities as valid. Recent political developments have added an additional layer of complexity to the barriers to care and disparities faced by this vulnerable population. In this talk, Dr. Deutsch will review current evidence in selected areas of gender affirming care for children, adolescents, and adults of all ages.

Bio - Maddie Deutsch, MD, MPH is a Professor of Clinical Family & Community Medicine at UCSF, and the founding Medical Director for the UCSF Gender Affirming Health Program, a multidisciplinary group of medicine, surgical, and behavioral health providers for trans and gender expansive adults at UCSF Health. She is a Co-Director for the UCSF School of Medicine Differences Matter Initiative, and a DEIB Co-Lead for UCSF Health. Dr. Deutsch has authored or co-authored more than 50 peer reviewed journal articles in the field of sexual and gender minority health, and was a co-author, and Primary Care Chapter Lead, for the recently released WPATH Standards of Care, 8th Version. She is the current President of the US Professional Association for Transgender Health.

Cheers,

Maddie

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, June 12, 2023 11:05 AM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds? - Your Info Needed

Sorry [redacted] I've been really overwhelmed and was on PTO last week. I will get you that by today!

From: [redacted]@ucsf.edu>
Sent: Monday, June 12, 2023 10:54 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds? - Your Info Needed

It would be great to get the info for your upcoming FCM Grand Rounds posted on the FCM website. Can you send me the info requested below?

Thanks.

[redacted]

Obtained via CPRA by Judicial Watch, Inc.

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[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu |https://fcm.ucsf.edu/

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From: [redacted]
Sent: Friday, June 2, 2023 5:01 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Hi Maddie,

I'm checking back with you about the info requested below.

Please send me your photo, bio, a title for your presentation, and a brief (paragraph) summary of your presentation.

Thanks.

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu |https://fcm.ucsf.edu/

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, November 21, 2022 1:09 PM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Great, thank you!

From: [redacted]@ucsf.edu>
Sent: Monday, November 21, 2022 12:37 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Great. Thanks, Maddie. You are confirmed for July 7, 2023. Here are some additional details:

About 4-5 weeks out, please send me your photo, bio, a title for your presentation, and a brief (paragraph) summary of your presentation. This will allow me to update our website with your upcoming presentation info and also give me what I need to send out our email invite to our broadcast list. I typically send the email about 3-4 weeks prior and then follow it up with a reminder the week of. Here's where we post the info so you can get a sense of what I'll need: https://fcm.ucsf.edu/family-community-medicine-grand-rounds

Please also send me your presentation materials (slides) a day or two before your event. I put these in a Box folder in case something goes wrong with your screen sharing the day of the presentation. This allows our tech expert, who will be on the webinar, what he'll need to jump in, if necessary.

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If you have any questions or concerns, just let me know. We look forward to your upcoming presentation on July 7, 2023.

Thanks.

[redacted]

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[redacted]M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu |https://fcm.ucsf.edu/

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
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Subject: Re: Present at UCSF FCM Grand Rounds?

Hi [redacted]et's do July 7. Please let me know when confirmed.

Thanks,

Maddie

From: [redacted]@ucsf.edu>
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To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
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January 6, 2023
July 7, 2023
August 4, 2023

If none of these work, we'd be moving into 2024. Do any of the above dates work?

Thanks.

[redacted]

[redacted]M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: [redacted]
Sent: Thursday, November 17, 2022 2:58 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
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Hi Maddie,

I'm waiting to hear back from two people about confirming dates, so once I hear back from them I'll let you know what is available. Thanks.

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[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
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Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Huge thanks, Maddie! I am eager to hear your presentation.
Happy Thanksgiving -
[redacted]

[redacted]MD, MPH

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Assistant Dean, Undergraduate Medical Education at UC Merced (interim)
Vice Chair of Education, UCSF Department of Family Medicine
Endowed Chair in Community Medicine, Vitamin Settlement Fund
Professor of Clinical Family and Community Medicine
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Sent: Thursday, November 17, 2022 12:23 PM
To: [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Hi [redacted], thanks for the invite, and I am sorry for my delayed reply. I'd be delighted to speak at FCM Grand Rounds. [redacted] please let me know what dates will work. Probably best to look at Feb and beyond.

Cheers,

Maddie

From: [redacted]@ucsf.edu>
Sent: Friday, November 11, 2022 4:33 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Present at UCSF FCM Grand Rounds?

Hi Maddie,
Would you be willing to give FCM Grand Rounds on the role of primary care clinicians in gender affirming care, or gender affirming care in the public health setting, or any related topic that you feel would be a better fit?

As you know, FCM GR focus on themes of health equity and social justice. Your work in gender affirming care seems like it a terrific fit for GR and would be of tremendous interest to our audience, which includes DFCM, 10 affiliated FCM residency sites, DPH primary care, and more.

GR is the first Friday of the month from 12-1pm by zoom. We are scheduling up to a year in advance. Here is a link to recent sessions.
https://fcm.ucsf.edu/family-community-medicine-grand-rounds

If you are willing to present, I will cc [redacted] who can help find a time that works for you.

I hope you are doing well. Thanks for considering!

[redacted]

[redacted]MD, MPH
Assistant Dean, Undergraduate Medical Education at UC Merced (interim)
Vice Chair of Education, UCSF Department of Family Medicine
Endowed Chair in Community Medicine, Vitamin Settlement Fund
Professor of Clinical Family and Community Medicine
University of California, San Francisco
[redacted]@ucsf.edu

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Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@umn.edu>
Sent: Thursday, June 15, 2023 5:45 AM PDT
To: [redacted]@umn.edu>; [redacted]@emory.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: can one of you answer this question?

This Message Is From an External Sender
This message came from outside your organization.

As I know, Spironolactone acts as an antiantrogen mainly by blocking the androgen receptor other than decreasing the testosterone secretion directly. We have also noticed that most of the testosterone levels of Chinese transgender females do not decrease after taking sipornolactone. So why there is a target level of suppressed testosterone (less than 50 ng/dL) during GATH as recommended in the current WPATH SOC 8 th?

Thanks!

--

[redacted]
Professor Emeritus
Eli Coleman Institute for Sexual and Gender Health
University of Minnesota Medical School
Family Medicine and Community Health
med.umn.edu/sexualhealth

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@umn.edu>
Sent: Thursday, June 15, 2023 5:46 AM PDT
To: [redacted]@umn.edu>; [redacted]@emory.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: another question...

This Message Is From an External Sender
This message came from outside your organization.

In the WPATH SOC, it is suggested that serum estradiol should be in the range of 100-200 pg/mL. But we've found that it is not easy to reach that level under the oral estradiol 2.0-6.0 mg/day, at least in our Chinese transgender female population. Moreover, in hormone replacement therapy for sexual active cisgender females, the recommended dose of estradiol is 2.0-4.0 mg/day, without any targeted estrogen level [Hum Reprod. 2016;31(5):926-37.]. So I am a little bit confused about the differences in estrogen regimen between transgender and cisgender females.

Really appreciate your help!

[redacted]
Professor Emeritus
Eli Coleman Institute for Sexual and Gender Health
University of Minnesota Medical School
Family Medicine and Community Health
med.umn.edu/sexualhealth

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@emory.edu>
Sent: Thursday, June 15, 2023 6:09 AM PDT
To: [redacted]@umn.edu>
CC: [redacted]@umn.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: [External] another question...

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Unfortunately, your Chinese colleagues are measuring estradiol at the wrong time. Please see paper of pharmakinetics of estradiol.

https://www.endocrinepractice.org/article/S1530-891X(21)01374-4/fulltext

Sent from my iPhone

On Jun 15, 2023, at 7:47 AM, [redacted]@umn.edu> wrote:

In the WPATH SOC, it is suggested that serum estradiol should be in the range of 100-200 pg/mL. But we've found that it is not easy to reach that level under the oral estradiol 2.0-6.0 mg/day, at least in our Chinese transgender female population. Moreover, in hormone replacement therapy for sexual active cisgender females, the recommended dose of estradiol is 2.0-4.0 mg/day, without any targeted estrogen level [Hum Reprod. 2016;31(5):926-37.]. So I am a little bit confused about the differences in estrogen regimen between transgender and cisgender females.

Really appreciate your help!

[redacted]
Professor Emeritus
Eli Coleman Institute for Sexual and Gender Health
University of Minnesota Medical School
Family Medicine and Community Health
med.umn.edu/sexualhealth

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From: [redacted]@whitman-walker.org> on behalf of Whitman-Walker Institute <[redacted]@wwc.ccsend.com>
Sent: Friday, June 16, 2023 8:00 AM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Gender-Affirming Care Weekly Newsletter

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Gender-Affirming Care Weekly Newsletter

June 16th, 2023

Resources

The Williams Institute released a new report titled ***Public Attitudes Toward the Use of Religious Beliefs to Discriminate Against LGBTQ People.***

Results show that 84% of U.S. adults oppose allowing medical professionals to deny health care to an LGBTQ person based on their religious beliefs.

Read the full report **here**.

Hearings

On Wednesday, the House Energy & Commerce Health Subcommittee held a hearing that included the *Children's Hospital GME Support Reauthorization Act of 2023*, a bill from Rep. Crenshaw (R-TX) that included a gender-affirming care rider. The hearing can be watched **here.**

Policy & Hill Updates

Lawmakers introduce bill to improve mental health resources for LGBTQ youth
Last week, Representatives Davids (KS), Sorensen (IL), and Torres (NY) introduced the **Pride in Mental Health Act**. The Act amends Title V of the Public Health Service Act to fund mental health resources for LGBTQ youth, cultural competency training, address school bullying, and to conduct a federal survey on mental health care and outcomes.

NYC mayor signs order protecting gender-affirming care
Executive Order 32 prevents city resources from being used to cooperate in an investigation of those who sought, received, provided, or facilitated gender-affirming care outside the state. It also prevents the use of city resources to detain any individual who is providing or receiving gender-affirming care in New York City.

AMA strengthens its policy on protecting access to gender-affirming care
The AMA House of Delegates passed the Endocrine Society's resolution to protect access to gender-affirming care for transgender and gender-diverse individuals. The AMA committed to opposing any criminal and legal penalties against patients seeking gender-affirming care, family members or guardians who support them in seeking medical care, and health care facilities and clinicians who provide gender-affirming care.

Nevada GOP governor signs transgender health bills while vetoing another, bucking party trends
On Monday, Governor Lombardo signed **SB163** requiring health insurance companies, including Medicaid, to cover all "medically necessary psychosocial and surgical intervention" for the treatment of gender dysphoria.

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Media Coverage

Four controversial doctors helping Republicans attack trans healthcare

In their continued effort to promote and legitimize anti-trans legislation, many Republican legislators have turned to the same several doctors as "experts" in gender-affirming care. Four of these doctors, who are highlighted in this article, have ties to right-wing and religious groups who oppose gender-affirming care, and have very little experience treating transgender patients. The four doctors described in the article are Dr. Patrick W Lappert, an Alabama-based plastic surgeon who has described identifying as transgender as "delusional thinking" and whose ability to testify as an expert has been limited by at least one judge who said he was "not qualified to render opinions" on the topic; Dr. Quentin Van Meter, a Georgia-based pediatric endocrinologist who has described online transgender communities as "cults" and who has been discredited as an expert by a Texas judge and barred from providing testimony on gender-affirming care; Dr. Paul Hruz, an associate professor of pediatrics specializing in diabetes at Washington University School of Medicine and who has testified in at least 10 lawsuits related to trans rights despite never having cared for a transgender patient; and Dr. Michael Laidlaw, a California-based adult endocrinologist who has compared providing gender-affirming care to youth to "the Tuskegee experiment on Black men" and has testified in favor of gender-affirming care bans despite admitting he has never conducted any research related to gender identity or worked with any patients diagnosed with gender dysphoria.

Florida Pediatricians Lose Round In Subpoena Fight

This week, a federal judge in Florida rejected a request to block a Florida House effort to obtain internal communications about how the Florida Chapter of the American Academy of Pediatrics developed standards of care for children diagnosed with gender dysphoria. Lawyers for AAP argued that the communications were protected by the First Amendment, but the judge ruled that the Florida HHS Committee has shown a legitimate interest in the records and that AAP had not shown that allowing them to see the records would cause any real harm. The subpoena in question would provide information related to guidelines established by WPATH and the Endocrine Society.

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IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

DYLAN BRANDT, et al., **PLAINTIFFS**

V. **4:21CV00450 JM**

LESLIE RUTLEDGE,[1] et al., **DEFENDANTS**

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Plaintiffs bring their claims under the Fourteenth Amendment's Equal Protection and Due Process Clauses and the First Amendment. Pursuant to Federal Rule of Civil Procedure 52(a), the Court makes the following specific findings of fact and conclusions of law. Act 626 is unconstitutional. The Court determines that Plaintiffs are entitled to judgment in their favor on all claims. The State is permanently enjoined from enforcing Act 626.

I. Procedural History

On April 6, 2021, the Arkansas Legislature passed House Bill 1570, Act 626 of the 93rd General Assembly of Arkansas, codified at Ark. Code Ann. §§ 20-9-1501 to 20-9-1504 and 23-79-164 ("Act 626").[2] Act 626 prohibits a physician or other healthcare professional from providing "gender transition procedures" to any individual under eighteen years of age and from referring any individual under eighteen years of age to any healthcare professional for "gender transition procedures."

> "Gender transition procedures" means the process in which a person goes from identifying with and living as a gender that corresponds to his or her biological sex to identifying with and living as a gender different from his or her biological sex, and may involve social, legal, or physical changes;

[1] Tim Griffin succeeded Leslie Rutledge as Arkansas Attorney General.
[2] The Arkansas Legislature titled the Act as "Arkansas Save Adolescents from Experimentation (Safe) Act." Because the title is misleading, the Court will refer to the Act as "Act 626" in this order.

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> (6)(A) "Gender transition procedures" means any medical or surgical service, including without limitation physician's services, inpatient and outpatient hospital services, or prescribed drugs related to gender transition that seeks to:
>
> (i) Alter or remove physical or anatomical characteristics or features that are typical for the individual's biological sex; or
>
> (ii) Instill or create physiological or anatomical characteristics that resemble a sex different from the individual's biological sex, including without limitation medical services that provide puberty-blocking drugs, cross-sex hormones, or other mechanisms to promote the development of feminizing or masculinizing features in the opposite biological sex, or genital or nongenital gender reassignment surgery performed for the purpose of assisting an individual with a gender transition.

AR LEGIS 626 (2021), 2021 Arkansas Laws Act 626 (H.B. 1570). The Act creates a private right of action for an "actual or threatened" violation. The Act does not define a "threatened violation." The statute of limitations for bringing an administrative or judicial proceeding under the Act is two years. However, an individual under eighteen years of age may bring an action throughout their minority through a parent and may bring an action in their own name for twenty years after reaching majority. A party who prevails under the Act must be awarded attorneys' fees.

Arkansas Governor Asa Hutchinson vetoed HB1570 because he believed it created "new standards of legislative interference with physicians and parents as they deal with some of the most complex and sensitive matters concerning our young people." He explained his concern that HB1570 "put[] the state as the definitive oracle of medical care, overriding parents, patients and health-care experts" and described the bill as a "vast government overreach." The Governor added that "The leading Arkansas medical associations, the American Academy of Pediatrics and medical experts across the country

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all" opposed the bill, voicing concerns that "denying best practice medical care to transgender youth can lead to significant harm to the young person." He also noted that HB1570 "does not grandfather in those young people who are currently under hormone treatment," and that those adolescents would "be left without treatment" when Act 626 went into effect. (Pls.' Ex. 17).

HB1570 was enacted into law as Act 626 on April 6, 2021, following the Legislature's override of Governor Hutchinson's veto. *See* Pls.' Ex. 16, at 10; Pls.' Ex. 26; Pls.' Ex. 27. A simple majority of the Arkansas General Assembly overrode the Governor's veto.

Plaintiffs filed a complaint alleging that Act 626 violates the Equal Protection Clause, Due Process Clause, and the First Amendment. Plaintiffs seek a declaratory judgment on each claim and a permanent injunction of enforcement of Act 626. Plaintiffs filed a motion for a preliminary injunction. After a hearing, the Court granted the motion for preliminary injunction on the record and filed a written order supplementing the ruling on August 2, 2021. The State appealed the Court's Order to the Eighth Circuit Court of Appeals. On August 25, 2022, the Eighth Circuit affirmed, *see Brandt by & through Brandt v. Rutledge*, 47 F.4th 661 (8th Cir. 2022).

The Court held an eight-day bench trial on this matter. At trial, the Court heard testimony from: Plaintiffs' fact witnesses—Plaintiffs Joanna Brandt, Dylan Brandt, Aaron Jennen, Donnie Ray Saxton, Amanda Dennis, and Dr. Kathryn Stambough; and Dr. Michele Hutchison;[3] Plaintiffs' expert witnesses—Dr. Dan Karasic, Dr. Deanna Adkins, Dr. Jack Turban, and Dr. Armand Antommaria; the State's fact witnesses—Dr.

[3] During the trial, the Court dismissed Plaintiff Hutchison as a party because she no longer practices medicine in the State of Arkansas.

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Stephanie Ho, Dr. Janet Cathey, Cathy Campbell, Dr. Roger Hiatt, Laura Smalts, and Clifton Francis "Billy" Burleigh Jr.; and the State's expert witnesses—Dr. Stephen Levine, Prof. Mark Regnerus, Dr. Patrick Lappert, and Dr. Paul Hruz.

The Court also received exhibits from both parties, as well as testimony from Defendant Amy Embry (the Rule 30(b)(6) designee of Defendant Arkansas State Medical Board), Dr. Rhys Branman and non-party Representative Robin Lundstrom by deposition designations.

The parties filed post-trial briefs (ECF Nos. 265, 266) and proposed findings of fact (ECF Nos. 257, 259) for the Court's consideration.

Plaintiffs contend that Act 626 categorically prohibits transgender adolescents[4] with gender dysphoria from treatment that the patient, their parents, and their medical providers agree is medically necessary and in the adolescent's best interest. They allege that the Act singles out individuals in need of medically necessary gender-affirming care solely because the individual's gender identity does not conform to their assigned sex at birth. The State asserts that Arkansas has a compelling government interest in protecting the health and safety of its citizens, particularly "vulnerable" children who are gender nonconforming or who experience distress at identifying with their biological sex. AR LEGIS 626 (2021). The State also contends that it has a compelling government interest in ensuring the ethical standards of the healthcare profession.

[4] Under Arkansas law, a minor is a person under the age of eighteen (18) years old. The term "adolescent" is used to describe a person from the time they begin puberty until they reach adulthood on their eighteenth birthday. For purposes of this opinion, the Court will use the terms "adolescent" and "minor" interchangeably.

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II. Findings of Fact[5]

A. Gender Identity, Gender Incongruence and Gender Dysphoria

1. "Gender identity" refers to a person's deeply felt internal sense of belonging to a particular gender. (Tr. 24:11-15, ECF No. 219 (Karasic)). It is a "core part of who you are." (Tr. 266:6-11, 267:11-15, ECF No. 219 (Adkins)).

2. Most people are "cisgender" and have a gender identity that aligns with their sex assigned at birth—the sex placed on their birth certificate at birth based on their external genitalia. (Tr. 24:16-20, ECF No. 219 (Karasic)).

3. Transgender people have a gender identity that does not align with their birth-assigned sex. (Tr. 24:21-23, ECF No. 219 (Karasic)).

4. "Gender incongruence" is a condition where a person's gender identity does not align with their birth-assigned sex.

5. There is no evidence that gender incongruence is the result of a dysfunctional family life, and many transgender people come from healthy, supportive families. (Tr. 100:4-16, ECF No. 219 (Karasic)).

6. Gender identity is not something that an individual can control or voluntarily change. *Id.* at 29:13-15 (Karasic); 267:11-15 (Adkins).

7. Efforts to change a person's gender identity to become congruent with their birth-assigned sex have been attempted in the past without success and with harmful effects. *Id.* at 29:16-20, 30:3-24 (Karasic).

[5] These facts are accurate as of the date of trial.

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8. Efforts to change an individual's gender identity can harm individuals by increasing feelings of shame and creating an expectation that change is possible when it is not, which can increase a sense of failure. *Id.* at 30:12-19 (Karasic).

9. Because efforts to change an individual's gender identity through therapy are ineffective, such efforts are now considered unethical by many mental health organizations including the American Psychological Association. *Id.* at 30:3-11 (Karasic); Tr. 325:18-326:4, ECF No. 220 (Turban).

10. Although people cannot voluntarily change their gender identity, a person's understanding of their gender identity can change over time. (Tr. 30:25-31:9, ECF No. 219 (Karasic); 266:12-267:15, 270:24-271:1 (Adkins); Tr. 331:9-15, ECF No. 220 (Turban)).

11. Research and clinical experience show that when gender incongruence continues after the onset of puberty, it is very unlikely that the individual will come to identify with their sex assigned at birth later in life. *Id.* at 310:16-25 (Turban); Tr. 267:25-268:7, 271:2-15, ECF No. 219 (Adkins); 98:7-25, 173:2-9 (Karasic).

12. The term "transgender male" refers to a person who was assigned female at birth who has a male gender identity. "Transgender female" refers to a person who was assigned male at birth who has a female gender identity.

13. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders-5 ("DSM") is a list of mental health disorders put out by the American Psychiatric Association and updated periodically. (Tr. 25:16-20, ECF No. 219 (Karasic)). It compiles criteria for psychiatric diagnoses that are generally relied on by practitioners in the psychiatric profession. *Id.* at 142:10-15 (Karasic).

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14. The lack of alignment between one's gender identity and their sex assigned at birth (gender incongruence) can cause significant distress. The medical term for this distress is gender dysphoria. *Id.* at 24:7-10 (Karasic).

15. Gender dysphoria can increase with the onset of puberty and the development of secondary sex characteristics that do not align with one's gender identity. *Id.* at 37:14-22 (Karasic).

16. The diagnostic criteria for gender dysphoria in adolescents and adults include incongruence between an individual's experienced or expressed gender and their sex assigned at birth lasting for at least six months and accompanied by clinically significant distress or impairment in social or occupational function. *Id.* at 26:20-27:3 (Karasic).

17. The diagnosis of gender dysphoria is made by a clinician who assesses whether a patient meets criteria based on a clinical interview, the clinician's observations of the patient, and the reports of the minor's parents. *Id.* at 27:7-28:1 (Karasic). This is how diagnoses of other mental health conditions are generally made. *Id.* at 28:2-5 (Karasic); Tr. 894:23-895:6, ECF No. 246 (Levine).

18. Gender dysphoria is a serious condition that, if left untreated, can result in other psychological conditions including depression, anxiety, self-harm, suicidality, and impairment in functioning. (Tr. 28:17-21, ECF No. 219 (Karasic); 236:11-19 (Adkins)).

19. It is widely recognized in the medical and mental health fields that, for many people with gender dysphoria, the clinically significant distress caused by the condition can be relieved only by living in accordance with their gender identity, which is referred to as gender transition. This can include social transition—e.g., dressing, grooming, and using a name and pronouns consistent with one's gender identity—and, for adolescents and

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adults, may also include gender-affirming medical care—i.e., medical treatments to align the body with one's gender identity. (Tr. 111:1-18, ECF No. 219 (Karasic); 197:16-20, 232:23-233:5 (Adkins); Tr. 324:18-325:3, ECF No. 220 (Turban)).

20. There is evidence of a rise in referrals to gender clinics in the United States in recent years. The increase in gender clinic patients is not surprising given the undisputed testimony that there is an increase in awareness of gender dysphoria and an increase in the number of gender clinics and insurance coverage for treatment, making such care available when it previously was not. (Tr. 77:17-78:15, 79:3-79:10, ECF No. 219 (Karasic)).

21. If any adolescents are seeking care at gender clinics because of social influence, they would not meet the criteria of gender dysphoria or be considered for gender-affirming medical treatment unless they had a longstanding incongruent gender identity and clinically significant distress. *Id.* at 87:6-88:1 (Karasic).

B. <u>The Science and Resulting Guidelines</u>

22. The Arkansas chapter of the American Academy of Pediatrics, the Arkansas Academy of Pediatrics, the American College of OB/GYN, the American Academy of Child Adolescent Psychologists, the American Academy of Child and Adolescent Psychiatry, the Arkansas Psychological Association, and other scientific and medical organizations all recognized the effectiveness and safety of gender-affirming medical care. (Pls.' Ex. 24 at 30:20-31:17, 32:4-19; Pls.' Ex. 25 at 40:19-42:16).

23. Two professional associations, the World Professional Association for Transgender Health (WPATH) and the Endocrine Society,[6] have published widely-accepted clinical

[6] Both associations joined in an Amici Curiae brief in support of Plaintiffs' Motion for Preliminary Injunction. (ECF No. 30).

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practice guidelines for the treatment of gender dysphoria. *Id.* at 31:11- 22, 33:22-34:1 (Karasic).

24. WPATH is a professional association that develops treatment recommendations through a committee of renowned experts in transgender health. *Id.* at 31:23-25, 32:13-18 (Karasic). WPATH has been publishing guidelines for the treatment of gender dysphoria and prior diagnoses related to gender incongruence since 1979. Its current version—the WPATH Standards of Care for the Treatment of Transgender and Gender Diverse People, Version 8—was published in 2022. *Id.* at 31:17-22 (Karasic).

25. The Endocrine Society is a professional society of over 15,000 endocrinologists and endocrinology researchers. (Tr. 383:11-14, ECF No. 220 (Antommaria)).

26. The Endocrine Society first published guidelines for the treatment of gender dysphoria in 2011 with a second edition in 2017. They are called Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Guideline. (Tr. 31:17-22, 33:12-17, ECF No. 219 (Karasic)).

27. The Endocrine Society Guideline for treatment of gender dysphoria is similar to other clinical practice guidelines published by the Endocrine Society concerning other medical treatments. *Id.* at 198:10-16 (Adkins).

28. Like other clinical practice guidelines, the WPATH Standards of Care and Endocrine Society Guidelines were developed by experts in the field, including clinicians and researchers, who used systematic processes for collecting and reviewing scientific evidence. *Id.* at 32:13-18, 102:14-103:2 (Karasic).

29. Both WPATH and the Endocrine Society, like other large medical and mental health associations such as the American Psychiatric Association, develop guidelines for

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treatment as well as advocate for policies relevant to their patient populations. *Id.* at 104:25-105:21 (Karasic).

30. The WPATH Standards of Care and Endocrine Society Guidelines for the treatment of gender dysphoria are recognized as best practices by the major medical and mental health professional associations in the United States, including the American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, the American Medical Association, and the American Academy of Child and Adolescent Psychology. *Id.* at 34:2-12 (Karasic).

31. The WPATH Standards of Care and Endocrine Society Guidelines are widely followed by clinicians. *Id.* at 34:13-19 (Karasic); 197:24-198:20, 273:5-8 (Adkins).

32. Transgender care is not experimental care.

33. Providing treatment for gender dysphoria does not cause a person to be or remain transgender and there is no treatment that can change a person's gender identity. *Id.* at 29:13-20, 98:7-99:21 (Karasic).

34. Under the WPATH Standards of Care and Endocrine Society Guidelines, treatment for gender dysphoria differs depending on whether the patient is a prepubertal child, an adolescent, or an adult. *Id.* at 35:20-37:13 (Karasic).

35. Under the WPATH Standards of Care and Endocrine Society Guidelines, before puberty, treatment is focused on support for the child and family. Some prepubertal children may socially transition. No medical interventions are indicated or provided for the treatment of gender dysphoria in prepubertal children. *Id.* at 36:5-10 (Karasic); 198:21-199:2 (Adkins).

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36. In addition to social transition, medical interventions such as medications to delay puberty ("puberty blockers" or "pubertal suppression"), hormone therapy, and in some more rare instances, surgery, may become medically indicated for youth who experience distress after the onset of puberty (i.e., during adolescence) under the WPATH Standards of Care and Endocrine Society Guidelines. *Id.* at 36:11-37:13; 38:19- 39:1 (Karasic); 199:3-12 (Adkins).

37. Under the WPATH Standards of Care and Endocrine Society Guidelines, treatment decisions for adolescents with gender dysphoria are individualized based on the needs of the patient, and gender-affirming medical treatments are not indicated or appropriate for all adolescents with gender dysphoria. *Id.* at 43:9-12 (Karasic); 200:18-24 (Adkins).

38. As with clinical practice guidelines in other areas of medicine, the WPATH Standards of Care recognize that it may be appropriate for doctors to deviate from the guidelines in individual cases where, in the clinician's judgment, such deviation is appropriate. (Tr., 35:11-19, 187:5-188:15, ECF No. 219 (Karasic)).

C. <u>Informed consent</u>

39. The WPATH Standards of Care and Endocrine Society Guidelines have provisions for informed consent for treatment that are consistent with principles of informed consent used throughout the field of medicine. (Tr. 401:4-15, ECF No. 220 (Antommaria)).

40. In general, before any medical treatment is provided to a patient, the health care provider must obtain informed consent. Informed consent means patients—and in the case of minors, their parents or guardians—are informed of the potential risks, benefits, and alternatives to treatment so they can weigh them and decide whether to pursue treatment. (Tr. 53:7-13, ECF No. 219 (Karasic); Tr. 380:10-19, ECF No. 220 (Antommaria)).

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41. In general, adolescents are able to understand the risks, benefits, and alternatives to a medical intervention. *Id.* at 381:1-8, 381:18-22 (Antommaria). The assent of adolescents—meaning their agreement with the proposed course of treatment— should be obtained. *Id.* at 380:20-381:8 (Antommaria).

42. Even when adolescents are able to understand the risks, benefits, and alternatives to treatment and assent to treatment, their parents or guardians must still provide informed consent. *Id.* at 380:1-9 (Antommaria).

43. The WPATH Standards of Care and Endocrine Society Guidelines provide that, before gender-affirming medical treatments are provided to adolescent patients, the patient and their parents or guardians must be informed of the potential risks, benefits and alternatives to treatment and consent must be provided by the parents or guardians. *Id.* at 400:11-401:3 (Antommaria); Tr. 274:7-275:19, ECF No. 219 (Adkins).

44. For hormonal therapy, the WPATH Standards of Care and Endocrine Society Guidelines specifically provide that patients and their parents or guardians must be informed of the potential impact of treatment on fertility and counseled on options for preserving fertility. (Tr. 400:11-21, ECF No. 220 (Antommaria); Tr. 53:25-54:12, ECF No. 219 (Karasic)).

45. The WPATH Standards of Care also provide that clinicians should inform families about the nature and limits of the evidence base regarding gender-affirming medical treatment for adolescents as part of the informed consent process. *Id.* at 55:7- 16 (Karasic).

46. The WPATH Standards of Care provide that, before any potentially irreversible medical treatments, families should be informed that some individuals may come to feel gender-affirming medical care is not a good fit for them as their feelings about their gender identity could change. *Id.* at 54:13-55:6 (Karasic).

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47. In some cases, a mental health diagnosis may impair an individual's medical decision-making capacity, in which case treatment would be delayed. (Tr. 382:7-11, ECF No. 220 (Antommaria); 321:12-322:3 (Turban)). Having a mental health diagnosis does not necessarily mean that an individual lacks medical decision- making capacity. *Id.* at 382:12-14 (Antommaria). If a patient suffers from depression or anxiety, that does not mean they cannot consent to treatment. *Id.* at 414:2-11 (Antommaria); Tr. 1056:3-22; ECF No. 248 (Lappert)).

48. The informed consent process is adequate to enable minor patients and their parents to make decisions about gender-affirming medical care for adolescents.

D. Medical Interventions

Step One: Psychotherapy

49. The WPATH Standards of Care spell out that the comprehensive mental health assessment prior to medical treatments for adolescents should include a thorough history of the person's gender identity and the stability of that identity; an assessment of other conditions that could affect presentation like a co-occurring psychiatric disorder; and the adolescent's cognitive maturity to make decisions and understand the future consequences of those decisions and their capacity to participate in care. (Tr. 43:13-45:2, ECF No. 219 (Karasic)).

50. The WPATH Standards of Care provide that any co-occurring mental health conditions should be addressed. *Id.* at 48:17-21 (Karasic); Tr. 199:21-24, ECF No. 219 (Adkins).

51. The WPATH Standards of Care recognize that autism spectrum disorder is present in higher rates among youth with gender dysphoria and that this needs to be considered when diagnosing and assessing a patient for treatment. WPATH Standards of Care

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recommend that when assessing patients who have autism spectrum disorder, more time may be needed and differences in communication should be taken into account. *Id.* 48:6-16 (Karasic).

52. The WPATH Standards of Care and Endocrine Society Guidelines recommend that mental health professionals should be involved in decisions about whether medical treatments are indicated and appropriate for a given adolescent. *Id.* at 45:23-46:9; 47:1-7 (Karasic); Tr. 307:13-22, ECF No. 220 (Turban). WPATH Standards of Care specifically recommend that "health care professionals involve relevant disciplines, including mental health and medical professionals, to reach a decision about whether [medical interventions] are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care."[7] (Tr. 45:23-46:9, ECF No. 219 (Karasic)).

53. The WPATH Standards of Care and Endocrine Society Guidelines provide for a comprehensive mental health assessment and diagnosis before an adolescent is provided gender-affirming medical treatment. *Id.* at 43:13-44:13,155:17-22 (Karasic); Tr. 322:10-19, ECF No. 220 (Turban).

54. Psychotherapy can be important for individuals with gender dysphoria to address and alleviate other conditions such as depression and anxiety, but it does not alleviate the underlying distress due to the incongruence between a person's gender identity and birth-assigned sex. (Tr. 29:16-20, 64:1-7, ECF No. 219 (Karasic)). There are no psychotherapeutic interventions that have been demonstrated to be effective at alleviating the gender dysphoria itself. *Id.* at 99:22-100:3 (Karasic).

[7] Quotes from the WPATH Standards of Care refer to the current edition, version 8.

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55. Not all individuals experiencing gender incongruence decide to seek treatment beyond psychotherapy.

Step Two: Puberty Blockers

56. The purpose of puberty blockers is to alleviate or prevent the worsening of the distress of gender dysphoria by pausing the physical changes that come with puberty. This treatment also provides the patient time to further understand their gender identity before initiating any irreversible medical treatments. *Id.* at 233:9-22 (Adkins); Tr. 318:7-22, ECF No. 220 (Turban).

57. Gonadotropin hormone-releasing hormone, or GnRH agonists (often referred to as puberty blockers), pause puberty at the stage it was in when treatment started. (Tr. 202:23-203:16; 233:6-14, ECF No. 219 (Adkins)).

58. Under the WPATH Standards of Care and Endocrine Society Guidelines, puberty blockers may be indicated as treatment for gender dysphoria for youth who have been confirmed to have started puberty, which is referred to as Tanner Stage 2. *Id.* at 205:3-15 (Adkins). Tanner Stage 2 begins at the first sign of puberty. (Tr. 205:5-7, ECF No. 219 (Adkins)). The age at which youth begin puberty varies significantly but typically starts between the ages of eight and fourteen for those assigned female at birth and between the ages of nine and fourteen for those assigned male at birth. *Id.* at 211:8-21 (Adkins).

Step Three: Hormone Therapy

59. The purpose of hormone therapy is to alleviate the distress of gender dysphoria by aligning the body to be more congruent with the individual's gender identity. *Id.* at 37:23-38:2 (Karasic); 234:3-8 (Adkins); Tr. 417:21-418:9, ECF NO. 220 (Antommaria).

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60. Under the WPATH Standards of Care and Endocrine Society Guidelines, hormone therapy—estrogen and anti-androgens for transgender girls, and testosterone for transgender boys— may be indicated for some adolescents with gender dysphoria. (Tr. 36:11-21, ECF No. 219 (Karasic)).

61. Transgender females treated with estrogen and anti-androgens will go through hormonal puberty like their cisgender female counterparts. They will develop typically female secondary sex characteristics such as breasts, softened skin, and fat distribution typical of females. *Id.* at 215:11-18 (Adkins).

62. The WPATH Standards of Care and Endocrine Society Guidelines do not recommend hormone therapy for adolescents with gender dysphoria unless the patient's articulation of their gender identity has been long-lasting and stable. The WPATH Standards of Care specifically provide that hormone therapy should be recommended to adolescents only if the experience of gender incongruence has lasted for years. (Tr. 50:20- 51:4, ECF No. 219 (Karasic)).

63. The WPATH Standards of Care and Endocrine Society Guidelines also require that, before providing hormone therapy, adolescents should demonstrate the emotional and cognitive maturity to understand the risks and be able to think into the future and appreciate the long-term consequences. *Id.* at 52:19-53:6 (Karasic); Tr. 400:22-401:15, ECF No. 220 (Antommaria).

64. The WPATH Standards of Care provide detailed guidance to clinicians about how to assess adolescents' maturity. (Tr. 58:17-59:8, ECF No. 219 (Karasic)).

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Step Four: Surgery

65. The Arkansas Children's Hospital Gender Clinic does not provide surgical treatment to patients. (Tr., ECF No. 275 at 605:8-11 (Stambough); 520:14-18 (Hutchison)).

66. Genital surgeries for adolescents are extremely rare. (Tr. 36:11-21, 55:10-16; ECF No. 219 (Karasic); Tr. 820:23-24, ECF No. 246 (Levine)). In their many years of treating adolescents with gender dysphoria, neither Dr. Karasic nor Dr. Adkins has ever referred a minor patient for genital surgery. (Tr. 186:23-25, 189:21-190:5, ECF No. 219 (Karasic); 231:17-19 (Adkins)).

67. With respect to genital surgeries for minors, the Endocrine Society Guideline does not recommend any such surgeries until after age 18. *Id.* at 38:19-39:9 (Karasic). The WPATH Standards of Care do not have an age threshold for vaginoplasty but recommends that it should be offered only to patients under 18 with great caution after a thorough assessment of the patient's maturity. It does not recommend phalloplasty for anyone under 18. *Id.* at 36:22-37:7, 38:8-18 (Karasic).

68. In the rare instance that an adolescent has gender-affirming surgery, the overwhelming majority of surgeries are chest surgeries for adolescent transgender males. *Id.* at 36:18-20 (Karasic).

69. The WPATH Standards of Care and Endocrine Society Guidelines provide that chest masculinization surgery may be appropriate for some transgender male adolescents prior to age 18 to help align the body with the individual's gender identity to alleviate gender dysphoria. There are no specific age requirements but, like the requirements for hormone therapy, the gender incongruence must be long-standing, and the patient must be deemed

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to have the cognitive maturity to understand the risks and effects of this treatment. *Id.* at 158:11-23 (Karasic).

E. Gender-Affirming Medical Care for Adolescents in Arkansas

70. The Arkansas Children's Hospital ("ACH") Gender Clinic is the primary provider of gender-affirming medical care for adolescents with gender dysphoria in Arkansas. It has seen more than 300 patients since it opened in 2018. (Tr. 516:13-517:1, 520:19-21, ECF No. 275 (Hutchison)).

71. The ACH Gender Clinic's protocols[8] are aligned with the WPATH Standards of Care and Endocrine Society Guidelines. *Id.* at 518:20-23 (Hutchison); 602:21-604:20 (Stambough).

72. In February 2022, leadership at ACH changed the protocols of the Gender Clinic to stop initiating gender-affirming medical care for patients under 18 who were not already receiving such treatment, while continuing such treatment for patients who were already receiving such care. *Id.* at 551:13-552:4 (Hutchison). The Hospital sent a letter to patients' families informing them that the change was due to concern that Act 626 might go into effect in the near future and disrupt patients' care. *Id.* at 552:5-17 (Hutchison); 602:10-20 (Stambough). The Clinic continues to provide hormone therapy to 81 patients under age 18. *Id.* at 602:21-603:4 (Stambough). Because the change in protocol was based on Act 626, Dr. Stambough expects that, if the law is permanently enjoined, the Gender Clinic will resume providing gender-affirming medical care for new patients. *Id.* at 603:5-10 (Stambough).

[8] References to ACH Gender Clinic protocols throughout these findings of fact refer to the protocols in place prior to February 2022, unless otherwise specified.

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73. Gender-affirming medical treatments that may be provided to adolescents at the ACH Gender Clinic include puberty blockers, estrogen, testosterone blockers, and testosterone. *Id.* at 518:24-519:15 (Hutchison).

74. The ACH Gender Clinic creates individualized treatment plans tailored to the particular needs of each patient. *Id.* at 521:1-9 (Hutchison); 604:2-6 (Stambough).

75. Not every adolescent patient seen at the ACH Gender Clinic requests or receives gender-affirming medical interventions. *Id.* at 522:4-11 (Hutchison); 604:21-606:19 (Stambough).

76. ACH Gender Clinic patients work with Clinic staff and their therapists to assess their gender identity. Some patients who have come to the Clinic with issues related to their gender identity eventually came to identify with their birth-assigned sex. Those patients did not receive medical interventions. *Id.* at 548:10-20 (Hutchison); 605:18-606:19 (Stambough).

77. Sometimes, ACH Gender Clinic staff do not feel some adolescent patients are ready for gender-affirming medical interventions and treatment will not be provided. *Id.* at 522:16-25, 539:18-22 (Hutchison).

78. Only four ACH Gender Clinic patients have been treated with puberty blockers. That is because most patients come to the Clinic at older ages when such treatment would not be indicated. (Tr. 519:12-15; 521:10-19, ECF No. 275 (Hutchison)). Patients who have already progressed significantly into puberty are not appropriate candidates for puberty blockers. *Id*. at 521:22-522:3.

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79. The ACH Gender Clinic protocols provide that the following criteria must be met before initiating hormone therapy (estrogen and testosterone blockers for transgender girls, or testosterone for transgender boys) for adolescents:

a. the patient must be assessed by the Clinic's psychologist;

b. the patient must meet the DSM-5 criteria for gender dysphoria;

c. the patient must have a consistent and persistent gender identity;

d. the patient must be in counseling with a therapist;

e. the patient's therapist must be consulted and must not identify any concerns about starting treatment;

f. the patient must have the cognitive maturity to understand and weigh the risks and benefits of treatment;

g. the patient's parent must provide informed consent;

h. the patient must receive a medical assessment including baseline lab work; and

i. the patient must be 14 years of age or older.

Id. at 524:16-526:9, 529:25-530:14, 531:7-9 (Hutchison).

80. The psychological evaluation conducted by the ACH Gender Clinic psychologist is comprehensive and includes an assessment for gender dysphoria, the patient's degree of dysphoria and the specific sources of distress, and other psychological assessments (e.g., for depression or anxiety) tailored to the patient's mental health needs. *Id.* at 526:18-527:12 (Hutchison).

81. The ACH Gender Clinic determines whether a patient's gender identity is persistent and consistent through information collected from the patient, the patient's parents, the

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patient's therapist, the Clinic psychologist, and the Clinic physician. *Id.* at 528:5-19 (Hutchison).

82. At the ACH Gender Clinic, it is common for Clinic patients to have a long-standing transgender identity by the time they come to the Clinic. The average length of time between when Clinic patients first identify as transgender and when they first tell a parent is 6.5 years. *Id.* at 528:20-25 (Hutchison).

83. The ACH Gender Clinic has very rarely had patients who only recently discovered their gender incongruence. In those cases, the patient would not be considered for hormone therapy for some time because there would be a need to see if the patient's gender identity remained consistent and persistent over time. *Id.* at 529:1-13 (Hutchison).

84. At the ACH Gender Clinic, the assessment of the patient's maturity is based on information from the parents, the Clinic psychologist, the Clinic physician, and the patient's therapist. *Id.* at 539:4-17 (Hutchison).

85. Where patients do not demonstrate the maturity to understand the potential risks and benefits of treatment, the ACH Gender Clinic will defer medical treatment. *Id.* at 539:18-540:1 (Hutchison).

86. In cases in which an ACH Gender Clinic patient's therapist has expressed concerns about beginning hormone therapy, e.g., if they had concerns about the patient's maturity or mood stability, treatment was delayed. *Id.* at 530:15-531:6 (Hutchison).

87. At the ACH Gender Clinic, no minor is provided hormone therapy unless the patient, their parents, their doctor, the Clinic psychologist, and the patient's therapist all approve treatment. *Id.* at 522:16-25, 530:15-531:14 (Hutchison).

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88. At the ACH Gender Clinic, for those patients who are treated with hormone therapy, the average length of time between a patient's first visit to the Clinic and the start of hormone therapy is about 10.5 months. *Id.* 529:18-24 (Hutchison).

89. The average age of beginning hormone therapy for ACH Gender Clinic patients is 16. *Id.* at 526:10-17 (Hutchison).

90. In the ACH Gender Clinic's informed consent process, the information provided to patients and their parents includes information about the possible risks and side effects of treatment, including potential risks to fertility related to hormone therapy and discussion of fertility preservation options. *Id.* at 531:15-532:18, 537:21- 538:14 (Hutchison); 613:20-614:3 (Stambough).

91. The ACH Gender Clinic's informed consent process includes informing families about the limitations on what is known about the effects and risks of treatments. *Id.* at 533:3-11 (Hutchison); 604:12-19 (Stambough).

92. Drs. Hutchison and Stambough similarly observed great distress in their gender dysphoric adolescent patients at the ACH gender clinic. Suicidal ideation and self-harm were common; some patients had attempted suicide, sometimes multiple times. *Id.* at 542:6-543:2 (Hutchison); 609:5-17 (Stambough).

F. The Parent and Minor Plaintiffs[9]

The Brandt Family

93. Plaintiff Dylan Brandt is 17 years old. (Tr. 658:8-12, ECF No. 275 (Joanna Brandt); 688:14-15 (Dylan Brandt)).

[9] Dylan Brandt, Sabrina Jennen, Brooke Dennis, and Parker Saxton are referred to collectively as the "Minor Plaintiffs." Joanna Brandt, Lacey and Aaron Jennen, Amanda and Shayne Dennis, and Donnie Saxton are referred to collectively as the Parent Plaintiffs. Kathryn Stambough is referred to as the Physician Plaintiff.

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94. Plaintiff Joanna Brandt is Dylan's mother. *Id.* at 658:6-9 (J. Brandt).

95. The Brandts live in Greenwood, Arkansas. *Id.* at 658:4-5 (J. Brandt); 688:10-11 (D. Brandt).

96. Dylan was assigned female at birth, but his gender identity is male. *Id.* at 659:10-15 (J. Brandt); 688:16-20 (D. Brandt).

97. Dylan's distress around his gender began before puberty. *Id.* at 689:13-24 (D. Brandt).

98. Dylan informed his mother of his gender dysphoria through a letter he gave her in June 2019, when he was 13 years old. *Id.* at 659:16-18 (J. Brandt).

99. Dylan has been diagnosed with gender dysphoria. *Id.* at 665:9-10 (J. Brandt).

100. After informing his mother, Dylan started socially transitioning—using he/him pronouns and the name Dylan. *Id.* at 691:4-10 (D. Brandt); 662:14- 19 (J. Brandt). He already had short hair but cut his hair shorter and in more typically masculine ways. *Id.* at 663:10-19 (J. Brandt). He also began to shop in the boys' section of stores. *Id.* at 663:20-664:4 (J. Brandt). Through these steps, Dylan began to be recognized as a boy more in public. *Id.* at 664:5-7 (J. Brandt).

101. Dylan's mood improved after he started to be recognized as a boy. *Id.* at 663:22-664:23 (J. Brandt).

102. Dylan was referred to the ACH Gender Clinic by his pediatrician. *Id.* at 665:11-16 (J. Brandt).

103. Dylan's first visit to the ACH Gender Clinic was in January 2020. *Id.* at 666:22- 25 (J. Brandt). At that visit, he and his mother met with Dr. Michele Hutchison— the director of the Gender Clinic at the time—and the Clinic's social worker. (Tr. 514:25-515:4, 517:14, ECF No. 275 (Hutchison); 667:1-7 (J. Brandt). Dr. Hutchison explained the

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possible treatment options for adolescents with gender dysphoria and the risks and benefits of those treatments. *Id.* at 667:8-18, 668:6-11 (J. Brandt).

104. During his first visit to the ACH Gender Clinic, Dylan and his mother and Dr. Hutchison discussed mental health therapy. Dylan had been in therapy prior to that visit, but he was between therapists at the time and the Gender Clinic referred him to a therapist near where he lived. *Id.* at 667:19-668:3 (J. Brandt).

105. Menstrual cycles were causing Dylan great distress, Dr. Hutchison prescribed menstrual suppression medication at that January 2020 visit. *Id.* at 668:16-669:5 (J. Brandt).

106. Menstrual suppression did not alleviate Dylan's gender dysphoria. *Id.* at 669:8- 10 (J. Brandt).

107. Eventually, Dylan began testosterone therapy in August 2020. This decision was made by his mother, a Clinic psychologist who evaluated him, his therapist, Dr. Hutchison, and Dylan. Everyone agreed it was appropriate for him.[10] *Id.* at 670:22-672:8 (J. Brandt)).

108. Dr. Hutchison had informed Dylan and his mother of the potential risks of treatment more than once. Joanna asked a lot of questions at the Clinic and had done research to make sure she was making the best medical decision for her child. *Id.* at 661:14-23, 662:20-663:7, 667:8-18, 668:6-15, 669:11-25, 670:1-21, 671:7-19 (J. Brandt).

109. As a parent, Joanna routinely makes medical decisions for her minor children. *Id.* at 658:13-21 (J. Brandt).

110. Dylan has now been on cross-sex hormone therapy for over two and a half years. *Id.* at 672:9-10 (J. Brandt).

[10] The trial transcript contains a typographical error. The visit at the ACH Gender Clinic was in August 2020, not August 2002 the date included in the trial transcript.

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111. Testosterone treatment has significantly alleviated Dylan's gender dysphoria. *Id.* at 673:3-25 (J. Brandt)).

112. Dylan has not experienced any negative side effects from testosterone therapy. *Id.* at 672:11-12 (J. Brandt); 694:14-19 (D. Brandt).

113. Dylan has continued regular therapy with a counselor. (Tr. 695:6-7, ECF No. 275 (D. Brandt).

114. If Act 626 were to go into effect, medically detransitioning is not an option for Dylan. *Id.* at 696:3-10 (D. Brandt). His mother Joanna fears that stopping treatment would negatively affect his mental health and he would "lose all" of "who he has become." *Id.* at 675:4-14 (J. Brandt).

115. Dylan and Joanna have discussed moving out of state or traveling out of state regularly for treatment if he cannot continue receiving treatment in Arkansas because of Act 626. *Id.* at 675:15-676:9 (J. Brandt); 696:11-12 (D. Brandt).

The Jennen Family

116. Plaintiff Sabrina Jennen is 17 years old. (Tr. 447:18-20, ECF No. 220 (Jennen)).

117. Plaintiffs Lacey and Aaron Jennen are her parents. *Id.* at 447:8-21 (Jennen).

118. Sabrina has two younger sisters. *Id.* at 447:18-21 (Jennen).

119. The Jennens live in Fayetteville, Arkansas. *Id.* at 459:25-460:1 (Jennen).

120. Sabrina was assigned male at birth, but her gender identity is female. *Id.* at 448:15-20 (Jennen).

121. Sabrina informed her parents of her gender dysphoria in July 2020, when she was 15. *Id.* at 448:21-449:23

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122. After informing her parents, Sabrina started to see a counselor, Cathy Campbell. *Id.* at 452:3-10, 454:1-2 (Jennen); Tr. 72:16-18, ECF No. 282 (Campbell). Sabrina continues to see Ms. Campbell regularly. (Tr. 454:3-8, ECF No. 220 (Jennen)).

123. Ms. Campbell diagnosed Sabrina with gender dysphoria. *Id.* at 453:15-25(Jennen); Tr. 77:12-78:2, ECF No. 282 (Campbell).

124. In the Summer of 2020, Sabrina started socially transitioning— she began to go by the name Sabrina and use she/her pronouns while at home. At the time, she and her family had just moved to Fayetteville, so she prepared to start the new school year as Sabrina. (Tr. 452:3-13, ECF No. 220 (Jennen)).

125. Sabrina and Ms. Campbell first discussed hormone therapy in September 2020 when Sabrina described her intense distress. (Tr. 75:15-76:7, ECF No. 282 (Campbell). After that session, Sabrina discussed hormone therapy with her parents, who were initially hesitant. *Id.* at 76:20-24 (Campbell); Tr. 454:11-18, ECF No. 220 (Jennen).

126. Because Ms. Campbell does not counsel patients about the medical risks of hormone therapy, she gave the Jennens Dr. Stephanie Ho's name and contact information so that they could speak with a medical doctor in Fayetteville who could best answer their questions. *Id.* at 76:25-77:8 (Campbell); Tr. 454:11-20, ECF No. 220 (Jennen)).

127. Sabrina's parents wanted to do more research and better understand the potential risks and benefits of hormone therapy before consenting to Sabrina beginning treatment. *Id.* at 454:21-455:17, 456:10-17 (Jennen).

128. Sabrina and her parents visited Dr. Ho's office in December 2020. *Id.* at 455:18-22 (Jennen). They met with a certified nurse practitioner who independently diagnosed Sabrina with gender dysphoria. (Tr. 82:18-83:1, ECF No. 282 (Ho). Dr. Ho's staff also

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provided verbal and written information to the Jennens about hormone therapy, including the risks and benefits and information related to fertility preservation, and answered the Jennens' questions. (Tr. 455:23-456:7, ECF No. 220 (Jennen)).

129. Before starting hormone therapy, Sabrina had therapy sessions with Ms. Campbell every other week for several months. *Id.* at 454:5-18 (Jennen); (Tr. 75:1-4, ECF No. 282 (Campbell)). During that time, Sabrina's parents participated in some joint family sessions with Ms. Campbell. *Id*. at 75:5-14 (Campbell); Tr. 453:18-23, ECF No. 220 (Jennen).

130. Sabrina and her parents discussed and researched hormone therapy. They "took a lot of time, thought and prayer" about whether Sabrina should undergo hormone treatment for her gender dysphoria, and they made the decision as a family to move forward with exploring hormone treatment. (Tr. 456:10-17, 457:15-19, ECF No. 220 (Jennen)).

131. Dr. Ho did her own assessment and diagnosed Sabrina with gender dysphoria. (Tr. 749:14- 16, ECF No. 224 (Ho)). She also reviewed with the family how hormone therapy works and the potential risks and benefits of the treatment. (Tr. 456:25-457:11, ECF No. 220 (Jennen)). Sabrina and her parents consented to Sabrina receiving hormone therapy, and Dr. Ho prescribed a testosterone blocker and estrogen. *Id.* at 457:15-19, 458:1-5 (Jennen).

132. Aaron and Lacey Jennen routinely make medical decisions for their children. *Id.* at 457:12-14 (Jennen).

133. Ms. Campbell had no concerns about Sabrina's ability to assent to hormone therapy. (Tr. 77:25-78:2, ECF No. 282 (Campbell)).

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134. Sabrina has regularly visited Dr. Ho for monitoring and treatment since January 2021. Approximately every three months, Dr. Ho reviews lab tests to monitor Sabrina's hormone levels and check in about Sabrina's dysphoria. (Tr. 458:6- 16, ECF No. 220 (Jennen)).

135. Sabrina's therapist and doctor agree that hormone therapy is benefitting Sabrina. (Tr. 78:24-79:9, ECF No. 282 (Campbell); Tr. 749:20-21, ECF No. 224 (Ho)).

136. Ms. Campbell could readily see the change in Sabrina's mental health after starting hormone therapy; she was happier and more outgoing than Ms. Campbell had ever seen her. (Tr. 78:3-16, ECF No. 282 (Campbell).

137. For Aaron Jennen, Sabrina not receiving gender-affirming medical care is "not an option." Tr. 462:5-8, 462:20- 463:11, ECF No. 220 (Jennen)). He testified that he would "worry about her withdrawing back into the person that she was before she started it, a person that was unhappy, that said things to her mother and I like, what's the point of life. Saying things like, I don't see a future for myself, which is difficult because how amazing she is." *Id.* at 463:12-20 (Jennen). Aaron testified that if Act 626 went into effect, they would either move or travel out of state to get treatment for Sabrina. *Id.* at 462:5-19 (Jennen).

The Saxton Family

138. Parker Saxton was 17 years old at the start of trial. (Tr. 430:14-15, ECF No. 220 (Saxton)).

139. Donnie Ray Saxton is Parker's father. *Id.* at 430:9-19 (Saxton).

140. The Saxtons live in Vilonia, Arkansas. *Id.* at 444:15-16 (Saxton).

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141. Parker was assigned female at birth, but his gender identity is male. *Id.* at 431:15-20 (Saxton).

142. Puberty caused significant distress for Parker. He suffered from anxiety and depression and would not socialize or answer his phone even with his closest friends. *Id.* at 432:12-15, 433:2-20 (Saxton). It was "troubling" for Donnie to watch. *Id.* at 433:2-7 (Saxton).

143. Donnie took Parker to see a therapist and psychiatrist who treated him for anxiety and depression. *Id.* at 434:7-18 (Saxton).

144. Parker was aware of his gender identity since around age 9. (Tr. 557:21-22, ECF No. 275 (Hutchison). He informed his father in a letter in 2019 when he was approximately 14 years old. (Tr. 431:24-432:4, 434:7-10; ECF No. 220 (Saxton)).

145. At the time Donnie read Parker's letter, he "didn't have a clue what transgender meant outside of what we see in the news and everything." *Id.* at 434:19-435:2 (Saxton).

146. If someone were to stereotype the most unlikely parent of a transgender child, it would be Donnie Ray Sexton. Donnie is a good and loving father.

147. In June 2020, when Parker was 15, Parker's psychiatrist referred him to the Gender Clinic at ACH. *Id.* at 435:11-14, 25 (Saxton).

148. At the ACH Gender Clinic, Parker initially was prescribed Depo-Provera as a menstrual suppressant to alleviate the distress caused by his period. *Id.* at 437:20-21 (Saxton).

149. The menstrual suppression helped alleviate some of Parker's gender dysphoria but did not fully address it. Parker still had depression, social anxiety, compulsive bathing, and an aversion to his reflection. *Id.* at 437:22-438:9 (Saxton).

150. Parker went to follow-up visits at the ACH Gender Clinic regularly. *Id.* at 438:14, 439:8 (Saxton).

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151. About three or four months after his first visit, Parker expressed that he thought testosterone might be helpful for him. *Id.* at 439:9-12 (Saxton).

152. On May 27, 2021, Parker began testosterone therapy. *Id.* at 442:21-25 (Saxton). Before starting treatment, Parker was evaluated by an ACH psychologist who confirmed the gender dysphoria diagnosis and conducted a psychological evaluation of Parker. *Id.* at 440:4-19 (Saxton). At the May 27th appointment, Parker, Donnie, and Dr. Hutchison extensively discussed the risks and benefits of treatment—including the potential impact on Parker's fertility—and they ultimately decided to move forward. *Id.* at 439:11-441:3, 442:25-443:15 (Saxton).

153. As a parent, Donnie routinely makes medical decisions for his children. *Id.* at 430:21-25 (Saxton).

154. Testosterone therapy has significantly alleviated Parker's gender dysphoria. *Id.* at 443:18-20 (Saxton).

155. Parker's doctors also observed the positive impact of testosterone therapy on Parker's gender dysphoria. (Tr. 559:9-23, ECF No. 275 (Hutchison); Tr. 619:13-15, EF No. 275 (Stambough).

156. Before Parker turned 18 in November 2022, the Saxton family talked about what they would do if Act 626 were to take effect and Parker could no longer receive testosterone therapy in Arkansas. It was a "hard talk," and they concluded that they'd "have to pick up and leave." (Tr. 445:21-446:17, ECF No. 220 (Saxton)).

157. After HB 1570 was introduced, the possibility of care being prohibited resulted in Parker Saxton going to such a "dark place" that his father started sleeping near him because of concern he might hurt himself. *Id.* at 441:15-24, 442:2-14 (Saxton).

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The Dennis Family

158. Plaintiff Brooke Dennis is 10 years old and is in fifth grade. (Tr. 638:18-21, ECF No. 275 (Dennis).

159. Plaintiffs Amanda and Shayne Dennis are her parents. *Id.* at 638:5-12 (Dennis).

160. Brooke has an older brother and a younger sister. *Id.* at 638:17-18 (Dennis).

161. The Dennises live in Bentonville, Arkansas. *Id.* at 650:3-10 (Dennis).

162. Brooke was assigned male at birth, but her gender identity is female. *Id.* at 639:11-15 (Dennis).

163. Brooke started identifying as a girl in second grade. *Id.* at 639:16-19 (Dennis).

164. Brooke continues to have fear, anxiety, and distress about the fact she could go through a typically male puberty. *Id.* at 620:21-621:6 (Stambough); 648:17-649:2 (Dennis).

165. Shortly after Brooke expressed her female gender identity to her mother in April 2020, the Dennises made an appointment for Brooke to see a therapist. *Id.* at 644:3-10 (Dennis). The Dennises wanted to have "as much information as possible to be able to make a good decision" on "how to move forward." *Id.* at 643:22- 24, 649:24-650:2 (Dennis).

166. After Brooke saw the therapist for a while, the therapist diagnosed Brooke with gender dysphoria. *Id.* at 644:13-17 (Dennis).

167. After the Dennises discussed Brooke's gender with her pediatrician, the pediatrician referred them to the ACH Gender Clinic. *Id.* at 644:18-645:6 (Dennis).

168. In October 2020, the Dennises had their first visit at the ACH Gender Clinic and met with Dr. Hutchison and other staff. *Id.* at 645:7-12 (Dennis). The purpose of the first visit was to help the family learn about the Clinic and the care they provided and get information about gender dysphoria and what they should be learning more about. *Id.* at 645:7-646:15

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(Dennis). They discussed Brooke's history and childhood. *Id.* at 645:22-25 (Dennis). No medical treatments for gender dysphoria were indicated for Brooke because she has not yet started puberty. *Id.* at 645:7-648:16 (Dennis); 620:18-20 (Stambough).

169. Brooke continues to express "a lot" of distress about her body related to her gender. She is specifically anxious about going through puberty. *Id.* at 620:18-621:6 (Stambough); 647:9-23, 648:7-649:11 (Dennis).

170. Brooke is still receiving counseling related to her gender dysphoria. *Id.* at 649:12-14 (Dennis).

171. As parents, Amanda and Shayne routinely make medical decisions for their three children. *Id.* at 649:15-17 (Dennis).

172. Act 626 is causing great anxiety for the Dennis family. Amanda and Shayne have discussed what they would do if Act 626 takes effect and Brooke is not able to get gender-affirming medical treatment in Arkansas. They would need to regularly travel out of state or move out of state to get Brooke care, and either scenario would be logistically, financially, and emotionally difficult. *Id.* at 652:11-22 (Dennis).

173. If the family were to move away, Amanda might have to give up her job as head of business operations for the digital ad platform at Sam's Club within the Walmart Enterprise, which would cause financial hardship for the family. *Id.* at 650:11- 14, 651:17-652:1, 654:3-656:18, 653:2-655:22 (Dennis).

174. Amanda Dennis testified about the financial impact on the family, as well as the impact on the care of her other two children and an aging relative, her job, and Brooke's attendance at school if she and Brooke had to regularly travel out of state for medical care. *Id.* at 652:11-657:11 (Dennis).

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G. Studies and Findings on Treatments Prohibited by Act 626

175. Decades of clinical experience have shown that adolescents with gender dysphoria experience significant positive benefits to their health and well-being from gender-affirming medical care. (Tr. 67:8-12, ECF No. 219 (Karasic); 233:15-22 (Adkins); Tr. 298:7-18, 305:2-19, ECF No. 220 (Turban); Tr. 543:3-544:11, ECF No. 275 (Hutchison); Tr. 606:20-608:6, 609:22-610:1, ECF No. 275 (Stambough)).

176. Clinical experience shows the long-term effectiveness of gender-affirming medical care as some adolescents with gender dysphoria are able to discontinue antidepressants and anti-anxiety medications after receiving gender-affirming medical care. (Tr. 231:23-232:7, ECF No. 219 (Adkins); Tr. 64:8-65:19, ECF No. 219 (Karasic)).

177. There are 16 scientific studies assessing the use of puberty blockers and hormone therapy to treat adolescents with gender dysphoria, and this body of research has found these treatments are effective at alleviating gender dysphoria and improving a variety of mental health outcomes including anxiety, depression, and suicidality. (Tr. 295:16-18, 298:7-18, 300:24-301:2, 301:5-17, 302:20-303:8, 303:22-305:1, ECF No. 220 (Turban); Tr. 68:15-69:14, ECF No. 219 (Karasic)).

178. The studies evaluating the use of puberty blockers to treat gender dysphoria saw improvements in mental health or that patients did not experience worsening of mental health as is typically the case when children with gender dysphoria go through puberty. (Tr. 299:5-301:2, 318:5-22, ECF No. 220 (Turban)).

179. The studies evaluating the use of hormone therapy to treat adolescents with gender dysphoria had findings similar to the results of dozens of studies of gender-

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affirming hormones for adults—both sets of studies found significant improvements in mental health. *Id.* at 302:20-303:21 (Turban).

180. Conclusions cannot be drawn from any single study (in any area of medical research), but the body of medical research as a whole shows that gender-affirming medical treatments are effective at improving mental health outcomes for adolescents with gender dysphoria. *Id.* at 300:21-301:2 (Turban).

181. The evidence base supporting gender-affirming medical care for adolescents is comparable to the evidence base supporting other medical treatments for minors. *Id.* at 389:25-390:3; 409:9-15 (Antommaria).

182. The evidence supporting gender-affirming medical care for adolescents with gender dysphoria includes scientific studies, that are cross-sectional and longitudinal, and clinical experience. *Id.* at 295:22-296:8, 299:5-14, 305:2-19 (Turban). Longitudinal studies follow mental health before and after treatment. *Id.* at 296:24-2951 (Turban). Cross-sectional studies compare people who receive treatment and do not receive treatment at one point in time. *Id.* at 296:3-6 (Turban).

183. There are no randomized controlled clinical trials evaluating the efficacy of gender-affirming medical care for adolescents. *Id.* at 296:9-13 (Turban). Such research is not possible because it would not be ethical or feasible to have a study in which a control group is not provided treatment that is known from clinical experience and research to benefit patients. *Id.* at 296:14-297:3 (Turban); 363:13-364:5, 385:23-386:7 (Antommaria). Additionally, it would not be possible to blind the studies to researchers and participants given the obvious physical effects of the treatments. *Id.* at 365:1-24,

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387:16-388:2 (Antommaria); 296:14-297:11 (Turban); Tr. 67:19-68:14, ECF No. 219 (Karasic).

184. It is common for clinical practice guidelines in medicine to make recommendations based on low or very low-quality evidence such as cross-sectional and longitudinal studies. (Tr. 377:24-378:2, ECF No. 220 (Antommaria); Tr. 1269:12-17, ECF No. 249 (Hruz)).

185. The treatments banned by Act 626 are widely recognized in the medical community, including by the major professional medical associations, as effective treatments for adolescents suffering from gender dysphoria, based on the clinical experience and scientific research. (Tr. 34:2-12, 102:3-103:12, ECF No. 219 (Karasic)).

186. There are no other evidence-based treatments besides those prohibited by Act 626 that are known to alleviate gender dysphoria. (Tr. 326:16-327:5, ECF No. 220 (Turban)).

H. <u>Potential Risks and Side Effects of the Gender-Affirming Care</u>

187. As with other medical treatments, gender-affirming medical treatments can have potential risks and side effects that must be weighed by patients and their parents after being informed of those risks and side effects by their doctors. (Tr. 390:4-392:4, 394:24-395:3, 400:11-21, 401:4-15, ECF No. 220 (Antommaria)).

188. The risks of gender-affirming medical care are not categorically different than the types of risks that other types of pediatric healthcare pose. *Id.* at 390:24-391:6 (Antommaria).

189. For many adolescents the benefits of treatment greatly outweigh the risks.

190. For many adolescents, gender-affirming medical care significantly alleviates the distress of gender dysphoria, improves their mental health, and enables them to engage in school and social activities.

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191. Adverse health effects from gender-affirming medical care are rare when treatment is provided under the supervision of a doctor. (Tr. 220:25-221:9, ECF No. 219 (Adkins)).

192. The evidence showed that the risks associated with the treatments prohibited by Act 626 are comparable to the risks associated with many other medical treatments that parents are free to choose for their adolescent children after weighing the risks and benefits. (Tr. 930:17, ECF No. 246 (Levine); Tr. 1319:2-4, ECF No. 249 (Hruz)). Off-label use of drugs is both permitted and common in Arkansas. (Pl.'s Ex. 9, at 137:21-25 (Embry)).

193. There is nothing unique about the risks of gender-affirming medical care for adolescents that warrants taking this medical decision out of the hands of adolescent patients, their parents, and their doctors.

194. It is common for adolescents to undergo medical treatments that carry comparable or greater risks than gender-affirming medical care. (Tr. 389:25- 390:3, 394:20-395:3, ECF No. 220 (Antommaria)).

195. There are treatments for conditions other than gender dysphoria that can impair a minor's fertility, e.g., treatments for certain rheumatologic conditions, kidney diseases, and cancers. *Id.* at 391:6-9; 417:8-12 (Antommaria); Tr. 222:23:19-24, ECF No. 219 (Adkins). Some of these treatments are provided at ACH, when appropriate for the particular patient. (Tr. 615:10-12, ECF No. 275 (Stambough)). Patients and families are similarly informed of the risk and weigh it in deciding whether to undergo the medical treatment. (Tr. 222:19-24, 227:2-5, ECF No. 219 (Adkins); Tr. 615:13-25, ECF No. 275 (Stambough)).

196. Except for the potential risk to fertility, the risks associated with puberty blockers, testosterone, estrogen and anti-androgens are the same regardless of the condition for

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which they are being used and whether they are used to treat birth- assigned males or birth-assigned females. (Tr. 206:18-21, 217:4-25, 219:13-220:2, ECF No. 275 (Adkins)).

197. Puberty blockers that are used to delay puberty as treatment for gender dysphoria are also used to treat other conditions, including central precocious puberty. Central precocious puberty is puberty that starts earlier than the typical age for the start of puberty. (Tr. 204:11-18, ECF No. 219 (Adkins); Tr. 1223:6-10, ECF No. 249 (Hruz)). Precocious puberty can occur when a child is as young as two. (Tr. 211:3-5, ECF No. 219 (Adkins)).

198. Decades of clinical experience and research on the use of puberty blockers, both for treatment of central precocious puberty and gender dysphoria, have shown this treatment to be safe. (Tr. 212:25-213:2, ECF No. 219 (Adkins)).

199. Patients on puberty blockers for precocious puberty are, on average, treated for a longer period of time than gender dysphoria patients. (Tr. 210:19-211:7, ECF No. 219 (Adkins)). For precocious puberty, pubertal suppression treatment can last as long as nine years. For gender dysphoria, pubertal suppression treatment typically does not last for more than three or four years. This is the case at the ACH Gender Clinic. (Tr. 210:19-211:7, ECF No. 220 (Adkins); Tr. 540:2-542:5, ECF No. 275 (Hutchison)).

200. An expected effect of puberty blockers is the delay of rapid accrual of bone mineralization that occurs during puberty. (Tr. 205:16-207:12, ECF No. 219 (Adkins); Tr. 390:8-16, ECF No. 220 (Antommaria)). While patients are on puberty blockers, they continue to accrue bone mineralization at prepubertal rate. (Tr., 209:2-13, ECF NO. 219 (Adkins)). Once puberty blockers are stopped and puberty resumes—either the person's endogenous puberty or an exogenous puberty prompted by hormone therapy—the accrual of bone mineralization increases at the usual pubertal rate. *Id.* at 209:2-210:1 (Adkins)).

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201. Generally, a patient will reach the normal range of bone density within "two to three years after [a patient is] on either gender-affirming hormones or go[es] through [endogenous] puberty." *Id.* at 210:2-7 (Adkins).

202. There have been some patients who do not achieve full bone density after treatment with puberty blockers. These patients tend to have had low bone density and risk factors for low bone density to begin with. Such risk factors include a family history of osteoporosis, low Vitamin D status, low physical activity, poor nutritional status, or low weight. *Id.* at 210:8-18 (Adkins).

203. Puberty blockers are fully reversible. If an adolescent discontinues such treatment, endogenous puberty will resume. *Id.* at 206:13-17, 208:21- 209:1 (Adkins).

204. If a patient treated with puberty blockers stops treatment and resumes their endogenous puberty, the medication has no impact on fertility. *Id.* at 208:21- 209:1, 222:25-223:1 (Adkins).

Masculinizing Hormone Therapy

205. Testosterone is used to treat cisgender adolescent male patients for a number of conditions including delayed puberty, hypogonadism (where the brain does not tell the body to go through puberty), and micropenis. *Id.* at 213:11-19 (Adkins); Tr. 1248:19-1249:2, ECF No. 249 (Hruz).

206. Risks associated with taking testosterone, regardless of the condition for which it is used or the birth-assigned sex of the patient, include changes in cholesterol profile and blood thickness (hematocrit) to the typical male range. *Id.* at 215:19-216:20, 217:4-9, 221:10-222:2, 278:8-12 (Adkins); Tr. 390:20-23, ECF No. 220 (Antommaria); Tr. 1249:23-1250:8, ECF No. 249 (Hruz).

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207. When treatment is monitored by a doctor to ensure appropriate therapeutic levels, adverse health effects are rare. (Tr. 220:25-221:9, ECF No. 219 (Adkins)).

208. When birth-assigned females are treated with testosterone, it can impact fertility. *Id.* at 216:21-217:3 (Adkins).

209. If testosterone therapy follows treatment with puberty blockers at Tanner 2 such that the ovaries never develop, it can cause infertility. This is discussed with patients and parents prior to initiating treatment. If maintaining fertility is important to the family, there are ways to manage treatment to preserve fertility, for example, by delaying the start of puberty blockers until a later stage of puberty or temporarily stopping blockers to allow ovaries to develop. *Id.* at 225:12-226:4; 226:5-22. (Adkins).

Feminizing Hormone Therapy

210. Hormone treatments used to treat transgender females with gender dysphoria— estrogen and anti-androgens—are used to treat many other conditions. (Tr. 203:1-25, ECF No. 219 (Adkins).

211. Estrogen is used to treat cisgender adolescent girls for a number of conditions including delayed puberty, ovarian failure, and Turner Syndrome (a congenital condition that prevents puberty from occurring). *Id.* at 214:3-11 (Adkins); Tr. 632:10-13, ECF No. 275 (Stambough); Tr. 1257:22-1258:10, ECF No. 249 (Hruz).

212. Anti-androgens are used to treat cisgender adolescent girls and women with polycystic ovarian syndrome and hirsutism. (Tr. 213:20-214:2, ECF No. 219 (Adkins); Tr. 1245:10-25, ECF No. 249 (Hruz)).

213. The risks of estrogen, regardless of the condition it is being used for and whether used on birth-assigned females or birth-assigned males, include blood clots (increasing stroke

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risk), lower hemoglobin levels, and increase in prolactin. (Tr. 218:1-219:16, ECF No. 219 (Adkins); Tr.1259:15-24, 1261:18-21, ECF No. 249 (Hruz)). Adverse health effects of feminizing hormone therapy present primarily among those who use excessive and unmonitored amounts of estrogen. (Tr. 278:13-279:8, ECF No. 219 (Adkins)).

214. The risks and side effects of anti-androgens, regardless of the condition it is being used for and whether used to treat birth-assigned females or birth-assigned males, include an increase in potassium levels. *Id.* at 217:10-25 (Adkins).

215. When treatment with estrogen or anti-androgens is monitored by a doctor to ensure appropriate therapeutic levels, adverse health effects are rare. *Id.* at 218:1-219:16; 220:6-21 (Adkins).

216. When estrogen is used to treat birth-assigned males, it can impact fertility. This is therefore discussed with patients and parents prior to initiating treatment and fertility preservation options are discussed. *Id.* at 219:17-220:12 (Adkins).

217. If feminizing treatment follows treatment with puberty blockers at Tanner 2 such that the testicles never developed, it can cause infertility. *Id.* at 225:17-226:4 (Adkins).

Chest Masculinization Surgery

218. The surgical risks of chest masculinization surgery are comparable to the risks related to other chest surgeries adolescents may undergo, including mastectomy or breast reduction for cisgender girls and gynecomastia surgery for cisgender boys. (Tr. 391:10-392:16, ECF No. 220 (Antommaria).

I. <u>Desistance, Detransitioning and Regret</u>

219. There are some individuals who undergo gender-affirming medical treatment who later come to regret that treatment and, for some, it was because they came to identify with

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their birth-assigned sex (sometimes referred to as detransitioning). This can happen with individuals who medically transitioned as adolescents or as adults. Regret over a medical procedure is not unique to gender-affirming medical care and is common in medicine. (Tr. 77:1-16, ECF No. 219 (Karasic)).

220. In Dr. Karasic's clinical experience treating thousands of patients with gender dysphoria over 30 years, none of his patients came to identify with their sex assigned at birth after medically transitioning. *Id.* at 72:11-18 (Karasic). Some of Dr. Karasic's patients have halted their medical transition for other reasons such as lack of insurance coverage or fear of losing family support. Some of these patients later resumed their medical transition. None of his patients who stopped or paused medical transition did so because they came to identify with their sex assigned at birth. *Id.* at 72:19-73:17 (Karasic).

221. Detransition is taken seriously by WPATH and medical providers. Parents and patients are advised of the potential that patients may ultimately come to a different understanding about their gender later in life. *Id.* at 75:13-24 (Karasic). The desistance studies relied on by the State to assert that gender incongruence will naturally desist for most youth were focused on prepubertal children and say nothing about the likelihood of gender incongruence desisting among adolescents, the group affected by Act 626. (Tr. 311:1-11, ECF No. 220 (Turban); Tr. 88:2-89:6, 93:2-17, ECF No. 219 (Karasic)).

222. "Watchful waiting" is an approach used by some health care providers with pre- pubertal children with gender dysphoria. It entails following prepubertal children with gender dysphoria and not encouraging social transition prior to puberty. It is not a recognized approach for adolescents with gender dysphoria because it is understood that, at that point, gender incongruence is unlikely to desist. Even gender clinics using the "watchful

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waiting" approach for prepubertal children provide gender-affirming medical care to patients whose gender dysphoria persisted past the onset of puberty. *Id.* at 96:21-98:6 (Karasic).

223. Providing gender-affirming medical care does not cause youth to persist rather than desist in their gender incongruence. Adolescents with gender dysphoria are unlikely to desist whether or not they receive gender-affirming medical care. And youth do not receive medical treatment unless their gender incongruence has persisted into adolescence. *Id.* at 96:16-20, 99:4-25 (Karasic).

224. Billy Burleigh and Laura Smalts testified about their experiences transitioning as adults and subsequently detransitioning. They stated they feel regret about their medical transitions. The Court finds these anecdotal experiences credible but also irrelevant to the issues to be decided. These witnesses' experiences are irrelevant to this case given that (i) neither sought nor received gender-affirming care as a minor (ii) both transitioned as adults (Tr. 1156:13-21, ECF No. 247 (Smalts); 1199:3-17, 1200:9-14 (Burleigh)); (iii) neither was treated in Arkansas *Id.* at 1157:2-11 (Smalts); 1210:15-23 (Burleigh)); (iv) they both detransitioned as a result of a religious experience and (v) continued to struggle with living consistently with their birth-assigned sex after deciding to detransition *Id.* at 1158:2-13, 1159:2-1160:2 (Smalts); 1203:10-1206:3, 1206:16-1207:1, 1207:8-13, 1207:22-25 (Burleigh)).

J. <u>Regulation of Medicine in Arkansas</u>

The Arkansas State Medical Board Regulates the Practice of Medicine in Arkansas

225. All states have medical boards that safeguard the practice of medicine by evaluating accusations of unprofessional conduct and taking disciplinary action against providers,

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which may include withdrawal of a medical professional's license. (Tr. 402:17-20, ECF No. 220 (Antommaria)).

226. The Arkansas State Medical Board (the "Board") is the state entity charged with regulating the practice of medicine in Arkansas. (Pl, Ex. 9 at p. 42:7-11 (Embry)). The Board's structure and functions are governed by the Arkansas Medical Practices Act ("AMPA"). (Pls.' Ex. 11, at Subchapter 3, p. 21-25).

227. The Board's mission is "to protect the public and act as their advocate by effectively regulating the practices of medical doctors. . .." (Pls.' Ex. 12; Pls.' Ex. 9 at 45:9-25 (Embry)). The Board regulates all the roughly 19,000-20,000 healthcare professionals whom it licenses. (Pls.' Ex. 9 at 42:20- 22, 43:19-25 (Embry)).

228. The Board is authorized "to promulgate and put into effect such rules and regulations as are necessary to carry out the purposes of the Arkansas Medical Practices Act." (Pls.' Ex. 9 at 46:2-6 (Embry); Pls.' Ex. 11 Section 17-95-303(2) at 23). While the Board typically enacts regulations pursuant to explicit statutory requirements or requests made by legislators, if the Board has a concern about how medical care is being provided in a particular field, it can also draft a rule regarding that subject and submit it to the legislature for approval. (Pls.' Ex. 9 at 46:15-47:21, 49:4-10, 49:20-505, 54:15-20, 62:25-63:19 (Embry).)

229. The Board tries to enact regulations that are consistent with best practices in a particular field. (Pls.' Ex. 9 at 60:22-61:3 (Embry)). The Board has worked with professional associations such as the Arkansas Medical Society in drafting rules, reviewing their best practice guidelines, and soliciting their expertise as professionals within their field. (Pls.'

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Ex. 9 at 59:8-60:21 (Embry)). The Board may also look to national groups like the American Medical Association for information. (Pls.' Ex. 9 at 63:20-64:10 (Embry)).

The Board Investigates and Disciplines Medical Providers for Unprofessional Conduct

230. The Board is authorized to investigate and discipline the medical practitioners whom it licenses for unprofessional conduct, including ethical violations as determined by the Board. (Pls.' Ex. 9, at 93:22-24, 96:6-976, 101:9-102:5 (Embry); Pls.' Ex. 11 Section 17-95-409(a)(1) -(a)(2) at 28-29). Investigations are often based on complaints filed with the Board. Sometimes issues come to the Board's attention through other means, such as the news. (Pls.' Ex. 9 at 43:9-18, 44:8-9, 72:21-74:18 (Embry)).

231. The Board may, and does, investigate whether doctors are practicing their profession in a way that could endanger the public health or welfare. (Pls.' Ex. 9 at 72:6- 18 (Embry); Pls.' Ex. 11 at 17-80-106(c)(2) at 2).

232. Failure to follow accepted medical practice can be a reason for investigation, and the Board considers accepted standards in a field of medicine when assessing whether there has been a violation of the AMPA. (Pls.' Ex. 9 at 81:16-19, 83:17-23 (Embry)).

233. The penalties that the Board may impose for unprofessional conduct include revoking or suspending licenses, issuing reprimands, imposing probation, and levying fines. (Pls.' Ex. 9 at 109:17-113:6, 114:3-115:3 (Embry); Pls.' Ex. 11 17-95-410(e)(3) at 29).

234. When issues concerning particular medical care arise, the Legislature and the Board pass laws and regulations to address how care is provided; they do not prohibit medical treatments. (Pls.' Ex. 9 at 137:11-20 (Embry)).

235. When over-prescription of opioids resulted in the opioid epidemic and caused harm to the public in Arkansas, the Legislature passed the Chronic Intractable Pain Treatment Act.

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(Pls.' Ex. 9 at 126:8-127:11 (Embry); Pls.' Ex. 11 Section 17-95-701 at 34-35). Rather than categorically banning opioids, the law provides a system of incremental sanctions for doctors who overprescribe opioids, beginning with monitoring prescribing habits, then voluntarily surrendering a DEA license for a period of time, then suspending the physician's license, and finally revoking the license. (Pls.' Ex. 11 Section 704(c)(1) at 35). Doctors have faced discipline for improper prescription of opioids under this section, including monitoring and the surrender of their DEA licenses. (Pls.' Ex. 9 at 130:5-8, 130:20-131:18 (Embry)). This system of incremental sanctions for improper prescription of opioids serves to effectively protect the public from harmful conduct. (Pls.' Ex. 9 at 131:19-22 (Embry)).

236. Because of serious risks related to gastric bypass surgery, the Legislature and Board established informed consent requirements before a doctor can perform gastric bypass surgery. (Pls.' Ex. at 132:13-133:2 (Embry); Pls.' Ex. 11 Subsections A through M of Rule 27 mandate a lengthy list of various complications and information that the informed consent process must address; Pls.' Ex. 9 at 133:23-134:6 (Embry)). This includes 33 potential surgical complications, nutritional complications, psychiatric complications, eight pregnancy complications, and 22 additional complications. *Id.* at 134:7-135:20 (Embry)). The rule further requires that licensees inform patients that there is no guarantee of weight loss or long-term weight management as a result of getting surgery, and that a lifetime of follow-up medical care is required. *Id.* at 135:4-20 (Embry)). The informed consent provisions in the Board's regulation related to gastric bypass surgery effectively protect the public from harm. *Id.* at 136:6-14 (Embry).

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237. After the FDA concluded that it was "no longer reasonable to believe that oral formulations of [hydroxychloroquine] and [chloroquine] may be effective in treating COVID-19, nor [was] it reasonable to believe that the known and potential benefits of these products outweigh their known and potential risks," (Pls.' Ex. 15). The Arkansas Department of Health updated its guidance to indicate that this use "should be avoided" in hospital and outpatient settings. But the guidance noted that "Unapproved use (i.e., 'off label use') of these medications is left to the discretion of individual clinicians and their patients." *Id.* The Board has not considered passing a regulation prohibiting the use of hydroxychloroquine to treat COVID. (Pls.' Ex. 9 at 143:21-24 (Embry)). The Board has received several complaints about a doctor inappropriately prescribing ivermectin to treat incarcerated people with COVID at a county jail. *Id.* at 78:8-79:14, 144:14-23 (Embry). The Board has not considered passing a rule prohibiting the use of ivermectin to treat COVID-19. *Id.* at 148:13-16 (Embry); Pls.' Ex. 18 at 81:21-82:21 (Branman).

238. Arkansas does not ban medical treatments for lack of randomized controlled clinical trials supporting their use. (Pls.' Ex. 9 at 206:23-207:4 (Embry)).

239. Arkansas does not ban medical treatments with a limited evidence base. *Id.* at 205:9-206:6 (Embry).

240. Even where there are known risks of a treatment and no evidence of effectiveness, the Board leaves treatment decisions to patients, parents, and their physicians. *Id.* at 208:10-16 (Embry).

241. Arkansas does not ban medical treatments for minors on the rationale that minors cannot provide informed assent. In Arkansas, parents usually are required consent to medical

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treatment for their minor children, and the decision about whether to undergo care is between the physician and the parent and the minor patient. *Id.* at 174:2-15 (Embry).

242. The Board is not aware of any minors in Arkansas who have been harmed by gender-affirming care. *Id.* at 227:17-22 (Embry).

243. The Board has never received a complaint regarding gender-affirming medical care for minors or adults. *Id.* at 152:3-16 (Embry); Pls.' Ex. 18 at 103:7-10 (Branman).

244. Since Embry became Executive Director in 2018, there has not been discussion about gender-affirming medical care for adults or minors at any Board meeting. (Pls.' Ex. 9 at 152:25-153:25, 217:2-6 (Embry)).

245. Since Embry has been director, the Board has not considered passing a regulation concerning gender-affirming medical care. *Id.* at 154:2-6 (Embry). No one at the Board ever suggested to Embry that they saw a need for a regulation concerning gender-affirming medical care. *Id.* at 154:7-11 (Embry).

246. If there is an issue regarding the over-prescription of gender-affirming medical treatment, the Board can propose a regulation to address that, as it did for the over-prescription of opioids. *Id.* at 210:25-211:11, 211:25-212:10 (Embry).

247. If there are doctors providing gender-affirming medical treatments to adolescents without adequately informing them of the risks of those treatments, the Board could propose an informed consent regulation, as it did for gastric bypass surgeries. *Id.* at 212:11-21, 213:20-25 (Embry).

248. The Board is the licensing entity for physicians who are providing procedures prohibited by Act 626. *Id.* at 179:25-180:6, 180:11-14 (Embry). The Board is ready to field any complaints alleging violations of Act 626 as those arise. *Id.* at 182:13-19 (Embry).

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249. If the Board receives a complaint that a doctor was providing gender-affirming medical care to an adolescent, the Board will follow the same general process that it uses for other complaints to determine whether the Act was violated. *Id.* at 182:4-12, 182:20-183:14 (Embry); Pls.' Ex. 18 at 108:3-110:3 (Branman).

250. Under the Act, the referral for or provision of gender transition procedures to a minor constitutes unprofessional conduct. (Pls.' Ex. 9 at 178:20-179:6 (Embry)). If a doctor provided gender-affirming care prohibited by Act 626, the Board would have to make a finding of unprofessional conduct under the statute. *Id.* at 184:25-185:6 (Embry). The doctor would then be subject to discipline by the Board, including the potential revocation of their license to practice. *Id.* at 185:7-9, 185:22-186:2 (Embry).

K. Policy Concerns Expressed at Trial

251. The Arkansas chapter of the American Academy of Pediatrics, the Arkansas Academy of Pediatrics, the American College of OB/GYN, the American Academy of Child Adolescent Psychologists, the American Academy of Child and Adolescent Psychiatry, the Arkansas Psychological Association opined that HB1570 would penalize medical providers for "simply following best medical practices to provide or even refer for appropriate effective care that is based in science and evidence," cause immediate and irreversible harm to adolescents receiving care in-state, and limit physicians' ability to refer youth to care supported by medical experts. (Pls.' Ex. 23 at 25:25-27:10, 27:11-21).

L. The Harm to Plaintiffs and Others Should Act 626 Take Effect

252. If Act 626 takes effect, adolescents whose parents and doctors agree that gender-affirming medical care is appropriate treatment for their gender dysphoria will be unable to receive that care in their home state and unable to get referrals from their doctors to

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receive care in other states. This will cause irreparable harm to the Plaintiff adolescents, Plaintiff parents and Plaintiff doctor.

253. The harms are severe and irreparable for adolescents with gender dysphoria who need but are unable to access gender-affirming medical care.

254. The fact that transgender adults face elevated rates of physical and mental health issues due to stigma, discrimination, and having lived with gender dysphoria is not a reason to deny treatment to adolescents with gender dysphoria; if anything, it supports the need for access to treatment. (Tr. 47:16-25, ECF No. 219 (Karasic))

255. Denying gender-affirming medical care to adolescents with gender dysphoria until they reach age 18 means their bodies would go through irreversible pubertal changes inconsistent with their gender identity. *Id.* at 234:18-235:7 (Adkins).

256. Delaying gender-affirming medical care when indicated puts patients at risk of worsening anxiety, depression, hospitalization, and suicidality. *Id.* at 236:11- 19, 237:1-5 (Adkins); 111:19-112:3 (Karasic)

257. Act 626 will impact Arkansas adolescents with gender dysphoria who need but are unable to access care. After ACH changed its policy in February 2022 to stop initiating gender-affirming medical care for new patients given the possibility of Act 626 taking effect, many patients for whom puberty blockers or hormone therapy are indicated have been unable to access care elsewhere. (Tr. 611:10-20, ECF No. 275 (Stambough)). These patients are experiencing anxiety and distress. *Id.* at 611:21-612:6 (Stambough).

258. Not all adolescents with gender dysphoria will live to age 18 if they are unable to get gender-affirming medical treatment. (Tr. 28:22-25, ECF No. 219 (Karasic) (testifying about adolescent patients with gender dysphoria who made suicide attempts); 236:14-25

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(Adkins) (testifying about losing a patient to suicide); Tr. 612:20-613:15, ECF No. 275 (Stambough) ("I am not hyperbolic when I say that I have concerns that not every patient would be able to make it to 18."); 549:12-18 (Hutchison) (testifying that she is "worried that we're going to lose some kids" if the law takes effect)).

259. For those adolescents who are already being treated with puberty blockers or hormone therapy and who would be forced to discontinue treatment, experts on both sides agree that the harms are severe.

260. The State's expert, Dr. Levine, described the psychological impact of cutting off gender-affirming medical care for those currently receiving it as "shocking" and "devastating." He testified he would expect doctors to "find a way" to help those patients, even providing treatment in violation of the law. (Tr. 913:6-914:4, 914:24-915:12, ECF No. 246 (Levine) (suggesting doctors would provide care "privately . . . that you don't know about," "under the radar")).

261. Discontinuing testosterone in transgender males would cause a decrease in facial and body hair growth, a return to a more typically feminine body shape, and lower muscle mass, resulting in the body not being well-aligned with their gender identity. (Tr. 235:8-17, ECF No. 219 (Adkins)).

262. Discontinuing testosterone suppression and estrogen in transgender females would result in the patient's beard coming back and shifts in body fat—less hips and chest—that do not align with their gender identity. *Id.* at 235:20-236:10 (Adkins).

263. Accessing care out of state is a considerable challenge with significant financial costs, and it is not something all families have the resources to do. Having to regularly travel out of state to take a child to doctor visits can be a great financial and logistical challenge

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to families. (Tr. 675:15-677:5, 696:13-24, ECF No. 275 (J. Brandt); 652:11-657:11 (Dennis); Tr. 462:20-463:11, ECF No. 220 (Jennen); 445:21-446:17 (Saxton).

264. Pursuant to Act 626, doctors who provide gender-affirming medical care to minor patients are engaging in unprofessional conduct and are subject to losing their medical license. (Pls.' Ex. 16 at 20-9-1504(a)).

265. Dr. Levine, the State's expert, expressed concern about the possibility of doctors losing their licenses for continuing to provide gender-affirming medical care. He testified that would be "[d]raconian" and a loss of a community resource. (Tr. 915:13-916:7, 917:16-918:11, ECF No. 246 (Levine)).

266. Requiring doctors to discontinue gender-affirming medical care that they are currently providing to adolescent patients—and prohibiting them from referring those patients to obtain care elsewhere—conflicts with their ethical obligation not to abandon patients under the AMPA. (Pls.' Ex. 14 at 20-6-202(a)(2); Pls.' Ex. 9 at 244:2, 19-22; 244:23-24; 236:17-237:4 (Embry)).

267. The AMPA provides that "healthcare providers are prohibited legally and ethically from abandoning a patient before treatment has been concluded." (Pls.' Ex. 14 at 20-6-202(a)(2); Pls.' Ex. 9 at 244:2, 19-22; 244:23-24; 236:17-237:4 (Embry)). Under this provision, if a doctor who is treating a patient is required to stop care before treatment is concluded, the doctor has an ethical obligation to help the patient find care from another doctor. *Id.* at 199:13-20 (Embry).

268. Doctors can be disciplined by the Board for abandoning a patient in violation of Ark. Code Ann. § 20-6-202. *Id.* at 201:5-9 (Embry). "Healthcare providers are prohibited legally and ethically from abandoning a patient before treatment has been concluded."

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Ark. Code Ann. § 202(a)(2). The Board recognizes the harms of abandoning patients prior to the completion of treatment. *Id.* at 237:23-238:3, 283:13-17 (Embry); Pls.' Ex. 18 at 130:18-19 (Branman).

M. Plaintiffs' Experts

Dan H. Karasic, M.D.

269. Dr. Dan Karasic is a psychiatrist with over 30 years of experience treating thousands of patients with gender dysphoria, including hundreds of adolescents. He is a professor emeritus of psychiatry at the University of California-San Francisco, where he has been on the faculty since 1991. Dr. Karasic received his medical degree from Yale School of Medicine and completed his residency at UCLA.

270. Dr. Karasic was a co-author of the current and previous versions of the WPATH Standards of Care and was on the committee to revise the categories of gender identity disorders for DSM-V. He has trained over 1,000 health care providers in transgender health care, served as an expert consultant to organizations including the United Nations Development Programme, and given invited presentations around the world. Dr. Karasic has also published several books and scholarly articles on transgender health. In 2006, Dr. Karasic was given the honor of being named a Distinguished Fellow of the American Psychiatric Association. (Pls.' Ex. 2; Tr. 23:11-20, ECF No. 219 (Karasic)).

271. Many of Dr. Karasic's patients, including adolescents, were profoundly impaired by gender dysphoria. He has had patients who were withdrawn from school or social interaction, patients who were suicidal or made suicide attempts, and patients who engaged in other forms of self-harm such as cutting their breasts or genitals, prior to getting treatment. *Id.* at 28:6-16, 29:9- 12 (Karasic).

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Deanna Adkins, M.D.

272. Dr. Deanna Adkins is a pediatric endocrinologist with 22 years of experience since completing medical school at the Medical College of Georgia and her residency at the University of North Carolina Hospitals. Dr. Adkins is an associate professor of pediatrics at Duke University, where she has been on the faculty since 2004. She is the director of the Duke University Child and Adolescent Gender Care Clinic.

273. She has treated approximately 600 adolescent patients with gender dysphoria.

274. Dr. Adkins also treats patients for a variety of other conditions requiring hormonal therapies, including differences of sexual development. (Pls.' Ex. 3; Tr. 195:25-196:21, 213:3-214:17, ECF No. 219 (Adkins)).

Jack Turban III, M.D.

275. Dr. Jack Turban is a child and adolescent psychiatrist whose work has focused on the treatment of patients with gender dysphoria. After completing medical school at Yale and his residency at Massachusetts General Hospital and McLean Hospital in Boston, Dr. Turban completed a fellowship in Child and Adolescent Psychiatry at Stanford University School of Medicine. Dr. Turban is an associate professor of child and adolescent psychiatry at the University of California, San Francisco School of Medicine where he treats adolescents and children with gender dysphoria. He also conducts scientific research on the mental health and treatment of adolescents with gender dysphoria and has published over 20 peer reviewed articles on the subject. (Pls.' Ex. 1; Tr. 292:10-293:6, 293:13-294:1, ECF No. 220 (Turban)).

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Armand H. Matheny Antommaria, M.D, Ph.D.

276. Dr. Armand Antommaria is a pediatrician, pediatric hospitalist, and bioethicist. He completed medical school at the Washington University School of Medicine and his residency at the University of Utah. He is currently the director of the Ethics Center at Cincinnati Children's Hospital Medical Center and a professor at the University of Cincinnati School of Medicine. As director of the Ethics Center, Dr. Antommaria provides clinical ethics consultation and works with a variety of medical teams to address ethical issues that arise in the care that they provide, including the transgender clinic and the differences of sex development clinic. He has also published numerous scholarly articles about medical ethics. (Pls.' Ex. 4; Tr. 357:19-359:11, ECF No. 220 (Antommaria)).

Kathryn Stambough, M.D.

277. Plaintiff Dr. Kathryn Stambough earned her medical degree from Washington University School of Medicine in St. Louis and completed a fellowship in Pediatric and Adolescent Gynecology at Baylor College of Medicine Texas Children's Hospital in Houston. (Tr. 598:2-9, ECF No. 275 (Stambough)).

278. Dr. Stambough is an assistant professor at the University of Arkansas for Medical Sciences ("UAMS") and a member of the Division of Pediatric and Adolescent Gynecology. *Id.* at 598:20-599:3 (Stambough).

279. Dr. Stambough has a clinical appointment at ACH where she practices in multiple clinics: the Gender Clinic; the Gynecology Clinic; the In-STEP Clinic, which cares for patients with differences of sexual development; and the Spinal Cord Disorders Clinic. She also

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has a clinical appointment and serves as a member of the team at UAMS in the Adult Gender Clinic. *Id.* at 599:14-600:22 (Stambough).

280. Dr. Stambough has been practicing in the ACH Gender Clinic since August 2020. She has been the Clinic's medical director since July 2022. *Id.* at 601:10-24 (Stambough).

281. Currently, 248 patients are being actively seen in the ACH Gender Clinic. *Id.* at 601:25-602:6 (Stambough).

282. The Clinic currently is providing hormone therapy to 81 patients. *Id.* at 602:21-603:4 (Stambough).

283. Dr. Stambough treats patients in the Gender Clinic, including with puberty blockers and hormone therapy. *Id.* at 604:2-20, 619:7-12 (Stambough).

284. Dr. Stambough has seen the distress of gender dysphoria experienced by her adolescent patients and how gender-affirming medical care alleviates that distress and improves her patients' health. *Id.* at 606:23-607:22 (Stambough).

285. If Act 626 takes effect, Dr. Stambough would be unable to provide medically necessary care to patients and would be forced to leave them to needlessly suffer. *Id.* at 610:2-21, 612:3-613:15 (Stambough).

286. In the course of her practice, Dr. Stambough sometimes refers patients to another healthcare provider which involves discussions with the patients and their families. *Id.* at 615:13-17 (Stambough). In making a referral, Dr. Stambough's discussion with her patients includes options for where to obtain the care. *Id.* at 615:18-25 (Stambough).

287. If Act 626 were to go into effect, Dr. Stambough would be unable to make all the referrals necessary to care appropriately for her Gender Clinic patients. *Id.* at 616:1-5 (Stambough).

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288. Some of Dr. Stambough's gender dysphoria patients would not be able to bring a lawsuit on their own behalf to challenge Act 626 for various reasons, including not being out to members of their extended family or keeping their gender identity private in certain other contexts. *Id.* at 618:20-25 (Stambough).

Plaintiffs' Expert Opinions Generally

289. Plaintiffs' experts' extensive experience, their testimony in court, and their demeanor and responsiveness to questions asked by both sides and the Court, show that all four of Plaintiffs' expert witnesses have deep knowledge of the subject matter of their testimony and were fully qualified to provide the opinion testimony they offered. They have provided credible and reliable testimony relevant to core issues in this case.

N. The State's Experts

Stephen B. Levine, M.D.

290. Dr. Stephen Levine is a licensed physician and Clinical Professor of Psychiatry at Case Western Reserve University School of Medicine where he attended medical school. He co-created the first gender identity clinic in Ohio in 1974 and has been seeing patients since that time. He has authored five books on sexual health, is the Senior Editor of the first three editions of the Handbook of Clinical Sexuality for Mental Health Professions. He has authored numerous invited papers, commentaries, chapters, and book reviews and was awarded a lifetime achievement award from the Society for Sex Therapy and Research in March 2005. (Def. Tr. Ex. 1).

291. Dr. Levine was the State's only expert witness who has experience treating patients with gender dysphoria. In his practice, he has enabled minor patients with gender dysphoria to access hormone therapy on a case-by-case basis. (Tr. 785:3-6, ECF No. 246 (Levine)).

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Dr. Levine does not support banning gender-affirming medical care for adolescents with gender dysphoria. He has concerns about Act 626's impact on youth who are currently receiving gender-affirming hormones.

292. Dr. Levine testified that doctors who provide gender-affirming medical care to adolescents with gender dysphoria encourage patients to identify as transgender and provide hormones immediately without assessing patients and addressing other mental health conditions or informing patients and their parents of the risks and the limitations of the evidence regarding treatments. *Id.* at 809:18- 810:4; 811:21-812:10; 824:5-14 (Levine). He offered no evidence that treatment was being provided this way in Arkansas or anywhere in the United States. Dr. Levine conceded he has no knowledge of how most gender clinics provide care and, thus, does not know how common it is for care to be provided in the way he described. *Id.* at 887:19-888:25 (Levine). He further does not know how care is provided by doctors in Arkansas. *Id.* at 888:24-891:16 (Levine).

293. The Court found Dr. Levine a very credible witness who struggles with the conflict between his scientific understanding for the need for transgender care and his faith.

Mark Regnerus, Ph.D.

294. Professor Mark Regnerus testified that all the major professional medical groups' support for gender-affirming medical care for adolescents with gender dysphoria is grounded in ideology rather than science. (Tr. 994:22-996:10, 1000:17-1001:1, ECF No. 248 (Regnerus)). Professor Regnerus' testimony did not offer any support for his conclusion, and the Court finds that there is no evidence to support this assertion.

295. Professor Regnerus, a sociologist whose work has focused on sexual relationship behavior and religion, has no training or experience related to the fields of medicine or

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mental health care, or the treatment of gender dysphoria. *Id.* at 974:5-977:22 (Regnerus). He has never worked in a medical or mental health clinical setting. *Id.* at 977:1-22 (Regnerus).

296. The Court does not credit the testimony of Professor Regnerus and gives it no weight because the Court finds that he lacks the qualifications to offer his opinions and failed to support them.[11]

Patrick W. Lappert, M.D.

297. Dr. Patrick Lappert is Board-Certified in Surgery and Plastic Surgery. He is the Founding Director of both the Pediatric Cleft Palate and Craniofacial Deformities Clinic and the Wound Care Center at Naval Hospital Portsmouth, Virginia. He served the Office of the Surgeon General-U.S. Navy as a Specialty Leader in Plastic and Reconstructive Surgery.

[11] This is not the first time that Professor Regnerus's testimony as an expert witness has been questioned by a court. The district court in *DeBoer v. Snyder* found that Regnerus's research and testimony that gay parenting caused adverse outcomes in children was "entirely unbelievable and not worthy of serious consideration" and a "fringe viewpoint that is rejected by the vast majority of [the studies' authors'] colleagues across a variety of social science fields." *DeBoer v. Snyder*, 973 F. Supp. 2d 757, 766-68 (E.D. Mich.), rev'd on other grounds, 772 F.3d 388 (6th Cir. 2014), rev'd sub nom. *Obergefell v. Hodges*, 576 U.S. 644, 135 S. Ct. 2584, 192 L. Ed. 2d 609 (2015); *see e.g., Kitchen v. Herbert*, 755 F.3d 1193, 1225 (10th Cir. 2014) (citing Rule 28(j) Letter at 2, No. 13–4178 (10th Cir., filed Apr. 9, 2014) (acknowledging that appellants' main scientific authority [Regnerus's research] on this issue "cannot be viewed as conclusively establishing that raising a child in a same-sex household produces outcomes that are inferior to those produced by man-woman parenting arrangements"); Ian Farrell & Nancy Leong, Gender Diversity and Same-Sex Marriage, 114 Colum. L. Rev. Sidebar 97, 101 (2014) (noting the "now-discredited study by Mark Regnerus" which was "suspect from creation--it was funded by conservative think tanks" and "suspect in methodology[.] . . . Moreover, Regnerus's department at the University of Texas publicly stated that it did not sanction his work. Social Science Research, in which the study originally appeared, later performed an audit and announced that the study should not have been published[.]"); Nathaniel Frank, What Does Mark Regnerus Want?, Slate (July 10, 2014, 10:20 AM), http://www.slate.com/blogs/outward/2014/07/10/mark_regnerus_is_back_with_more_anti_gay_family_science.html (on file with the Columbia Law Review); Philip N. Cohen, 200 Researchers Respond to Regnerus Paper, Family Inequality (June 29, 2012, 11:00 AM), http://familyinequality.wordpress.com/2012/06/29/200-researchers-respond-to-regnerus-paper/ (on file with the Columbia Law Review) (finding peer-review process abnormally short and questioning reviewers' expertise and impartiality); Dep't of Sociology, Statement from the Chair Regarding Professor Regnerus, Univ. of Tex. at Austin (Apr. 12, 2014), http:// www.utexas.edu/cola/depts/sociology/news/7572 (on file with the Columbia Law Review) ("Dr. Regnerus' opinions ... do not reflect the views of the Sociology Department of The University of Texas at Austin."); Darren E. Sherkat, The Editorial Process and Politicized Scholarship: Monday Morning Editorial Quarterbacking and a Call for Scientific Vigilance, 41 Soc. Sci. Res. 1346, 1347-49 (2012) (finding "serious flaws and distortions" in Regnerus's paper)).

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298. Dr. Lappert has no training or professional experience in mental health or gender dysphoria and has never provided gender-affirming surgery. He acknowledges that he is not an expert in the treatment of gender dysphoria. (Tr. 1040:16-1042:18, ECF No. 248 (Lappert)).

299. Like Professor Mark Regnerus and Dr. Paul Hruz, Dr. Lappert was recruited by the Alliance Defending Freedom ("ADF") at a seminar held in Arizona. The meeting was held to gather witnesses trained in various fields that would be willing to testify in favor of laws passed that limit transgender care. The ADF is an organization committed to protecting God's design for marriage and family. (Tr. 1029:16-1031:24, ECF No. 248 (Regnerus)). The ADF is not a scientific organization, but a Christian-based legal advocacy group. *Id.* at 1080:21-25 (Lappert). While there is nothing nefarious about an organization recruiting witnesses to testify for their cause, it is clear from listening to the testimony that Professor Mark Regnerus, Dr. Paul Hruz, and Dr. Lappert were testifying more from a religious doctrinal standpoint rather than that required of experts by *Daubert*.

300. Dr. Lappert offered opinions regarding the circumstances under which he believes cosmetic or aesthetic surgeries are ethically appropriate in adults and minors and the potential risks of various surgeries outside of the context of gender transition. The relevance of Dr. Lappert's testimony was unclear. The Court finds that he is not qualified to offer relevant opinions given his lack of experience related to gender dysphoria.

301. Dr. Lappert does not meet the requirements under *Daubert* to give opinions relevant to this case.

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302. Dr. Lappert acknowledged that his opinions were his own and were inconsistent with his peers and the American Society of Plastic Surgeons. *Id.* at 1080:5-9, 1081:16-21 (Lappert).

Paul W. Hruz, M.D., Ph.D.

303. Dr. Paul Hruz is a Pediatric Endocrinologist. He is currently the Associate Professor of Pediatrics, Endocrinology and Diabetes and the Associate Professor of Pediatrics, Cell Biology & Physiology at Washington University of St. Louis School of Medicine. He received his M.D. and Ph.D. in Biochemistry from the Medical College of Wisconsin. He received certification in Healthcare Ethics from the National Catholic Bioethics Center in 2017. In addition to teaching and authorship of many articles and papers, Dr. Hruz practices Pediatric Endocrinology at St. Louis Children's Hospital.

304. Dr. Hruz has never treated a patient for gender dysphoria. (Tr. 1317:21-23, ECF No. 249 (Hruz)).

305. The legislative findings in Act 626 assert that there is insufficient evidence of the efficacy of gender-affirming medical care for minors. Some of the state's expert witnesses—Dr. Levine and Dr. Hruz—offered opinions to that effect. (Tr. 833:12-16, ECF No. 246 (Levine); Tr. 1274:15-25, ECF No. 249 (Hruz)). The Court does not credit these opinions because it finds that the evidence showed that decades of clinical experience in addition to a body of scientific research demonstrate the effectiveness of these treatments. For the same reason, the Court finds that the treatments banned by Act 626 are not "experimentation" on youth, as suggested by the Act's title. ARK. CODE ANN. § 20-9-1501 (2021) ("Arkansas Save Adolescents from Experimentation (SAFE) Act"); Tr. 382:25-383:4, ECF No. 220 (Antommaria)).

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306. Dr. Hruz suggested that the Court should disregard the body of research showing benefits of gender-affirming medical care for adolescents because it is low-quality research, and the studies have methodological limitations such as lack of a control group or cross-sectional design. (Tr. 1275:20-1277:4, 1277:18-1278:21, 1279:7-1280:22, 1291:14-1292:8, ECF No. 249 (Hruz)). The Court declines to do that. The Court finds that the quality of the evidence supporting gender-affirming medical interventions for adolescents with gender dysphoria is comparable to the quality of evidence supporting many other medical treatments minors and their families may pursue. And while the Court recognizes that the studies on gender-affirming medical care for adolescents, like studies in all areas of medical research, have strengths and weaknesses, it does not credit Dr. Hruz's assessment that the entire body of research is, therefore, meaningless. The body of research, taken as a whole, shows these treatments provide significant benefits to adolescents with gender dysphoria.

307. Dr. Hruz also testified about risks of puberty blockers, testosterone, anti-androgens, and estrogen, suggesting this is a basis to prohibit gender-affirming medical care for adolescents. *Id.* at 1247:4-10; 1257:11-20, 1261:18-25; 1262:1-1263:13 (Hruz). The weight of evidence speaks to the contrary.

308. Like Plaintiffs' experts, Dr. Hruz recognized that apart from the potential impact on fertility, the risks of these treatments also exist when these medications are provided to treat other conditions in cisgender patients. *Compare Id. with* 1229:24- 1230:22, 1249:14-1250:8, 1259:15-1260:3 (Hruz). These risks have not prevented Dr. Hruz from providing these medications to cisgender patients in his pediatric endocrine practice. *Id.* at 1222:22-24, 1244:11-17, 1248:16-18, 1257:21-24 (Hruz).

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Defendant's Expert Opinions Generally

309. The State suggests that Act 626 is consistent with medical guidelines issued by "nations around the world." *See* Def. Tr. Br. at 21. Their experts referenced guidelines issued by government health authorities in Sweden, Finland, and the United Kingdom. But the Court finds that the evidence showed that none of these guidelines have prohibited gender-affirming medical care for minors. (Tr. 405:19-406:6, 406:20-407:24, ECF No. 220 (Antommaria)).

310. In Sweden, Finland and the United Kingdom, gender-affirming medical care is provided to adolescents with gender dysphoria when indicated under their guidelines. For example, in Finland, the guidelines provide that hormone therapy can be provided to minors based on a thorough case-by-case consideration if it can be ascertained that the adolescent's identity as the other sex is of a permanent nature and causes severe dysphoria. (Tr. 938:23-939:3, ECF No. 246 (Levine)). In the United Kingdom, the National Health Service has expanded care from one central clinic to regional clinics to broaden access to care. (Tr. 406:20-407:19, ECF No. 220 (Antommaria)).

311. Most of the State's expert witnesses, Professor Mark Regnerus, Dr. Stephen Lappert, and Dr. Paul Hruz, were unqualified to offer relevant expert testimony and offered unreliable testimony. Their opinions regarding gender-affirming medical care for adolescents with gender dysphoria are grounded in ideology rather than science. *See also Doe v. Ladapo*, 2023 WL 3833848, at *2 (N.D. Fla. June 6, 2023) (comments on expert testimony of Lappert and Hruz); *Kadel v. Folwell*, 620 F. Supp. 3d 339, 368 (M.D.N.C. 2022) (same).

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III. Conclusions of Law

A. Standing

Constitutional standing requires that at least one plaintiff demonstrate they have suffered a concrete and particularized injury that is fairly traceable to the challenged action and is likely to be redressed by a court ruling in the plaintiff's favor. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61 (1992). "To show standing under Article III of the U.S. Constitution, a plaintiff must demonstrate (1) injury in fact, (2) a causal connection between that injury and the challenged conduct, and (3) the likelihood that a favorable decision by the court will redress the alleged injury." *Iowa League of Cities v. EPA*, 711 F.3d 844, 869 (8th Cir. 2013) (citations omitted). The undisputed evidence at trial established that, if the Act were to go into effect, (i) three of the Minor Plaintiffs—Parker Saxton, Dylan Brandt, and Sabrina Jennen—would have to discontinue treatment that they, their parents, and their doctors all agree is medically indicated for them and benefitting their health and well-being, and Minor Plaintiff Brooke Dennis would be unable to obtain treatment she will imminently need; (ii) the Parent Plaintiffs would have to watch their children suffer the loss of care or endure severe personal and financial hardship to access care for their children in other states, and (iii) the Physician Plaintiff, Dr. Kathryn Stambough, would be unable to treat her patients who need care, leaving them to suffer, and unable to refer them to other doctors to provide care when necessary. As the Court has held, those injuries are directly traceable to the Act and would be redressed by a permanent injunction barring its enforcement. The evidence presented at trial confirms that Plaintiffs have standing to pursue their claims.

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B. Equal Protection

The Equal Protection Clause of the Fourteenth Amendment "is essentially a direction that all persons similarly situated should be treated alike." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985) (citing *Plyler v. Doe*, 457 U.S. 202, 216 (1982)). "Put another way, state action is unconstitutional when it creates 'arbitrary or irrational' distinctions between classes of people out of 'a bare ... desire to harm a politically unpopular group.'" *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 607 (4th Cir. 2020), as amended (Aug. 28, 2020) (quoting *Cleburne*, 473 U.S. at 446–47). It protects against intentional and arbitrary discrimination. *See Vill. of Willowbrook v. Olech*, 528 U.S. 562, 564 (2000) (per curiam). State action is generally presumed to be lawful and will be upheld if the classification drawn by the statute is rationally related to a legitimate state interest. *City of Cleburne*, 473 U.S. at 440.

The rational basis test, however, does not apply when a classification is based upon sex. Rather, a sex-based classification is subject to heightened scrutiny, as sex "frequently bears no relation to the ability to perform or contribute to society." *Id.* at 440–41 (quoting *Frontiero v. Richardson*, 411 U.S. 677 (1973)). Act 626 discriminates on the basis of sex because a minor's sex at birth determines whether the minor can receive certain types of medical care under the law. *Brandt by & through Brandt v. Rutledge*, 47 F.4th 661, 669 (8th Cir. 2022). The evidence presented at trial supports this conclusion. A minor assigned male at birth is not prohibited under Act 626 from receiving testosterone or surgical procedures "such as subcutaneous mastectomy, voice surgery, liposuction, lipofilling, pectoral implants, or various aesthetic procedures" for the purpose of aligning himself with his biological sex. Act 626 does not prohibit a minor

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assigned female at birth from receiving estrogen or surgical procedures "such as augmentation mammoplasty, facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation, hair reconstruction or other aesthetic procedures" to enhance her appearance as long as the enhancements align with her biological sex. "The biological sex of the minor patient is the basis on which the law distinguishes between those who may receive certain types of medical care and those who may not. The Act is therefore subject to heightened scrutiny." *Id.* at 670 (citing *Heckler v. Mathews*, 465 U.S. 728, 744 (1984)).

The Act also discriminates against transgender people. The law prohibits medical care that only transgender people choose to undergo, i.e, medical or surgical procedures related to gender transition.[12] "[T]ransgender people constitute at least a quasi-suspect class." *Grimm v. Gloucester Cty. Sch. Bd.*, 972 F.3d 586, 607 (4th Cir. 2020); *accord Bostock v. Clayton County*, 140 S. Ct. 1731, 1741 (2020) (discrimination for being transgender is discrimination "on the basis of sex"). Transgender people satisfy all indicia of a suspect class: (1) they have historically been subject to discrimination; (2) they have a defining characteristic that bears no relation to their ability to contribute to society; (3) they may be defined as a discrete group by obvious, immutable, or distinguishing characteristics; and (4) they are a minority group lacking political power. *See Grimm*, 972 F.3d at 610-613.

"[A]ll gender-based classifications today warrant heightened scrutiny." *United States v. Virginia*, 518 U.S. 515, 555 (1996) (citing *J.E.B. v. Alabama ex rel. T.B.*, 511 U.S. 127,136 (9th Cir. 1994) (internal quotation marks omitted)); *see also Harrison v.*

[12] The State argues that people who are not transgender may seek gender transition procedures. There is no evidence in the record to support this argument.

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Kernan, 971 F.3d 1069, 1077 (2020); *Flack v. Wis. Dept. of Health Servs.*, 328 F. Supp. 3d 931, 952 (W.D. Wisc. 2018) (recognizing that "heightened scrutiny may be appropriate either on the basis of sex discrimination or through recognizing of transgender as a suspect or quasi-suspect class.")).

"Statutes that discriminate based on sex must be supported by an 'exceedingly persuasive justification.' The government meets this burden if it can show that the statute is substantially related to a sufficiently important government interest." *Brandt by & through Brandt v. Rutledge*, 47 F.4th 661, 670 (8th Cir. 2022) (quoting *United States v. Virginia*, 518 U.S. 515, 531-33 (1996)). Heightened or intermediate scrutiny imposes a burden "rest[ing] entirely on the State" to demonstrate an "exceedingly persuasive" justification for the differential treatment. *Virginia*, 518 U.S. at 533. A state "must show at least that the [challenged] classification serves important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives." *Id.* (internal quotation marks and citations omitted). And "[t]he justification must be genuine, not hypothesized or invented post hoc in response to litigation." *Id.*

The State claims that by banning gender-affirming care the Act advances the State's important governmental interest of protecting children from experimental medical treatment and safeguarding medical ethics. Throughout this litigation, the State has attempted to meet their heavy burden by offering the following assertions in support of banning gender-affirming medical care for adolescents: (i) that there is a lack of evidence of efficacy of the banned care; (ii) that the banned treatment has risks and side effects; (iii) that many patients will desist in their gender incongruence; (iv) that some patients

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will later come to regret having received irreversible treatments; and (v) that treatment is being provided without appropriate evaluation and informed consent. The evidence presented at trial does not support these assertions.

a. Efficacy

The evidence at trial showed that the prohibited medical care improves the health and well-being of many adolescents with gender dysphoria. Three of Plaintiffs' experts and two Arkansas doctors detailed the significant mental health benefits of gender-affirming medical care for adolescents with gender dysphoria which they have observed clinically. Drs. Karasic, Turban, and Adkins have collectively treated thousands of patients with gender dysphoria and testified about their own clinical experiences witnessing the positive, life-changing impact of gender-affirming medical interventions on their adolescent patients as well as the comparable experiences of their colleagues around the country. (Tr. 67:8-12, ECF No. 219 (Karasic); 233:15-22 (Adkins); Tr. 298:7-18, 305:2-19, ECF No. 220 (Turban); Tr. 543:3-544:11, ECF No. 275 (Hutchison), 606:20-610:1 (Stambough). Drs. Stambough and Hutchison similarly testified about the many positive impacts of gender-affirming medical interventions on the health and well-being of their adolescent patients in Arkansas. (Tr. 543:3-544:11, ECF No. 275 (Hutchison), 606:20-610:1 (Stambough)). The testimony showed that the benefit of this care is long lasting. *Id.*

The State put forth no evidence contesting the extensive clinical experience of Plaintiffs' witnesses. In fact, the State's only expert witness to have ever treated patients for gender dysphoria, Dr. Levine, testified that he felt a decision about whether an adolescent should pursue hormone therapy should be made by a "team of well-informed

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doctor[s], scientifically well-informed, parents that have a respect for the doctor and have met with the doctor numerous times, and the doctor who has a relationship with the patient." (Tr. 909:7:25, ECF No. 246 (Levine)). He went on the say that "after that patient has had a process of psychotherapy where these matters, their ambivalence, the uncertainty, their eating disorders, and their self-harm episodes, et. cetera, have been thoroughly explored—if that team of doctors, patient, and parent want to do that [hormone therapy] that's what doctors do. We do that for cancer as well, you know." *Id.*

Plaintiffs' experts testified about the body of research demonstrating that the banned medical interventions improve patient health. (Tr. 295:16-18, 298:7-18, 300:24-301:17, 302:20-303:8, 303:22-305:1, ECF No. 220 (Turban); 219:68:15-69:14 (Karasic)). Dr. Turban testified about the sixteen studies conducted in multiple countries over the past twenty years that collectively show that use of pubertal suppression and gender-affirming hormones to treat adolescents with gender dysphoria improves patient health and prevents the worsening of distress upon the onset of puberty. *Id.* at 295:16-18 (Turban). He testified as well that the studies about the efficacy of hormone therapy show positive outcomes consistent with dozens of studies about the efficacy of such therapy to treat gender dysphoria in adults. *Id.* at 302:20-303:21 (Turban).

This expert testimony about positive research and clinical evidence was bolstered by the unrebutted testimony of the Parent Plaintiffs who explained how gender-affirming medical care positively transformed the lives of their adolescent children with gender dysphoria. For adolescents, like Minor Plaintiffs Parker Saxton, Dylan Brandt, and Sabrina Jennen, this care allowed them to grow from depressed, anxious, and withdrawn young people into happy and healthy teenagers who looked forward to their futures.

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The State offered no evidence to refute the decades of clinical experience demonstrating the efficacy of gender-affirming medical care. Additionally, the State's experts offered no evidence-based treatment alternatives. When asked at trial what would happen if a law like Act 626 were to go into effect, Dr. Turban explained:

> It would be emotional to think about. Because the reality is that we frequently in clinic have families that are coming to us with these young people who are really struggling with severe anxiety, depression, sometimes suicidal thoughts, sometimes their mental health is declining so dramatically that they can't go to school, and it's my job to tell families what the evidence-based approaches are to help their child. So if these treatments were not an option, I'd be left without any evidence-based approaches to treat this young person's gender dysphoria.

(Tr. 326:16-327:5, ECF No. 220 (Turban)).

The evidence showed that based on the decades of clinical experience and scientific research, it is widely recognized in both the medical and mental health fields—including by major medical and mental health professional associations—that gender-affirming medical care can relieve the clinically significant distress associated with gender dysphoria in adolescents.[13] The State failed to provide sufficient evidence that the banned treatments are ineffective or experimental.

b. <u>Risks and Side Effects</u>

It is undisputed that puberty blocking hormones delay the rapid accrual of bone mineralization that occurs during puberty. (Tr. 205:16-201:12, ECF No. 219 (Adkins)); Tr. 390:8-16, ECF No. 220 (Antommaria)). This is a risk for cisgender and transgender

[13] The State urges the Court to disregard the major medical organizations' views about gender-affirming medical care for adolescents with gender dysphoria, claiming they are based on ideology rather than science. To support this claim, they offered the testimony of Professor Mark Regnerus, but his testimony did not offer any support for this assertion. *See* Pls.' Proposed FOF ¶ 383. To accept this claim would require the Court to both credit Professor Regnerus' testimony and the notion that every major medical association in the United States is driven by ideology rather than science and patient well-being. There is no basis and no evidence supporting such a conspiratorial assessment of all the major medical associations.

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adolescents. Puberty blocking hormones do not stop bone mineralization. Instead, adolescents on these hormones continue to accrue bone mineralization at a prepubertal rate. (Tr. 209:2-13, ECF No. 219 (Adkins)). Once puberty blockers are stopped and puberty resumes, either the person's endogenous puberty or an exogenous puberty prompted by hormone therapy, the accrual of bone mineralization increases at the usual pubertal rate. *Id.* at 209:2-210:1 (Adkins).

It is undisputed that when adolescent birth-assigned females with gender dysphoria are treated with testosterone, their fertility can sometimes be impaired. If testosterone follows puberty blockers at certain stages of the adolescent's development, the adolescent can become infertile. These risks are discussed with patients and parents and fertility options are discussed. There are also risks associated with testosterone therapy given to cisgender adolescent males including changes in cholesterol profile and blood thickness. However, Dr. Adkins testified that when a doctor monitors treatment to ensure appropriate therapeutic levels, adverse health effects are rare. *Id.* at 220:25-221:9 (Adkins).

Estrogen and anti-androgens are used to treat birth-assigned males with gender dysphoria. It is undisputed that when estrogen is used to treat birth-assigned males, it can sometimes impair their fertility. If estrogen treatment follows puberty blockers at certain stages of the adolescent's development, the adolescent can become infertile. When estrogen or anti-androgens are given to birth-assigned males, the hormones can limit the patient's sexual arousal or ability to orgasm. *Id.* at 229:17-230:2 (Adkins). These risks are discussed with patients and parents. The risks can be managed by the doctor to preserve fertility or treatment can be provided to address a decrease in sexual satisfaction in most

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cases. There are also risks for cisgender females from treatment with estrogen or anti-androgens. Again, when a doctor monitors treatment to ensure appropriate therapeutic levels, adverse health effects are rare.

The State failed to provide sufficient evidence that Act 626's ban on transgender care is justified by the risks of the treatment. As stated, the evidence at trial showed the risks associated with gender-affirming care for adolescents are no greater than the risks associated with many other medical treatments that are not prohibited by Act 626. (Tr. 390, ECF No. 220 (Antommaria); Tr. 212:11-12, ECF No. 219 (Adkins)). The evidence showed that the banned treatments are effective to treat gender dysphoria and the benefits of the treatments greatly outweigh the risks. The State failed to meet their burden to show that the risks of gender-affirming care banned by Act 626 substantially outweigh the benefits.

c. <u>Desistance and Regret</u>

The State argues that minors with gender dysphoria will desist with age. They contend that there is a significant risk of harm to a minor who elects to undergo gender hormone therapy or surgery because they will eventually identify with their sex assigned at birth and regret the treatment they sought as a minor. The State offered the testimony of Dr. Levine to support this argument. The Court found Dr. Levine's testimony to be inconsistent and unreliable in this area. To the contrary, the evidence proved that there is broad consensus in the field that once adolescents reach the early stages of puberty and experience gender dysphoria, it is very unlikely they will subsequently identify as cisgender or desist. (Tr. 310:13-25, ECF No. 220 (Turban)). The testimony confirmed

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that for most people gender identity is stable over their lifetime. (Tr. 31, ECF No. 219 (Karasic)).

d. Proper Evaluation and Informed Consent

The State spent a great deal of time at trial arguing that the number of children identifying as transgender has increased in the last decade and researchers theorize that the increase could be due to mental illness, social encouragement, or abuse. The State argues that the "affirmative" model of treating gender dysphoria which utilizes puberty blockers, cross-sex hormones and surgeries allows doctors to "throw caution out the window." (Post-Tr. Br., ECF No. 265 at 4). However, there was no evidence that doctors in Arkansas negligently prescribe puberty blockers or cross-sex hormones to minors.

The State argues that many doctors do not require mental health counseling before treatment and will let children get hormone therapy and permanently altering surgeries upon demand. The evidence at trial did not support the State's argument. The State's experts admitted that they have had no contact with any Arkansas doctors or information about how doctors in Arkansas treat minors with gender dysphoria. (Tr. 113:1-12, ECF No. 246 (Levine)). There was no evidence presented that surgeons in Arkansas are performing gender transforming surgeries on minors much less performing surgeries on demand. In fact, the evidence confirmed that doctors in Arkansas do not perform gender transition surgeries on any person under the age of 18, the age which Act 626 targets.

There was testimony that WPATH Standards of Care, which are aligned with the ACH Gender Clinic protocols, recommend a comprehensive bio-psychosocial assessment of adolescent patients who present with gender identity related concerns and seek gender transition care. (Tr. 43:13-47:7, ECF No. 219 (Karasic)). The Standards of Care

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"recommend healthcare professionals involve relevant disciplines including mental health and medical professionals to reach a decision about whether puberty suppression, hormone initiation, or gender-related surgery for gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until transition is made to adult care." *Id.* Before initiating gender-affirming medical treatment to adolescents, the WPATH Standards of Care state that the patient should have a history of gender diversity lasting years and meet the criteria for a gender dysphoria diagnosis. *Id.* at 50-51. The diagnostic criteria for gender dysphoria includes six months of clinically significant distress or social or occupational impairment. *Id.* This six-month period is in addition to the years of gender diversity history that the Standards of Care require. *Id.*

Dr. Hutchinson testified that while she was the medical director at the Arkansas Children's Hospital Gender Clinic she always did a full assessment of an adolescent seeking care for gender dysphoria. (Tr. 523:10-528:19, ECF No. 275 (Hutchison)). Her assessment included family history, physical history, and psychosocial evaluations. *Id.* Before cross-sex hormone therapy could be prescribed in the Clinic, the adolescent had to meet the criteria for a gender dysphoria diagnosis, meet with a clinical psychologist, have ongoing therapy with a therapist, show consistent and persistent gender identity in their affirmed gender and show mood stability. *Id.* Dr. Cathey, an Arkansas doctor, testified that she requires a diagnosis of gender dysphoria before prescribing feminizing or masculinizing hormone therapy to minors (Tr. 754-759, 54-59, ECF No. 224 (Cathey)). After a diagnosis, she will prescribe hormones to minors aged 16 and older but only with parental consent. *Id.*

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Rather than protecting children or safeguarding medical ethics, the evidence showed that the prohibited medical care improves the mental health and well-being of patients and that, by prohibiting it, the State undermined the interests it claims to be advancing. Further, the various claims underlying the State's arguments that the Act protects children and safeguards medical ethics do not explain why only gender-affirming medical care—and all gender-affirming medical care—is singled out for prohibition. The testimony of well-credentialed experts, doctors who provide gender-affirming medical care in Arkansas, and families that rely on that care directly refutes any claim by the State that the Act advances an interest in protecting children.

Based on the record, the Court concludes that Act 626 prohibits medical care on the basis of sex and the State has failed to meet its demanding burden of proving the Act advances its articulated interests. The Court finds that Act 626 violates Plaintiffs' rights to equal protection.

C. Due Process

Even if the Court found that Act 626 passed constitutional muster under the Equal Protection Clause, it fails under due process analysis. The Due Process Clause of the Fourteenth Amendment forbids states to "deprive any person of life, liberty, or property, without due process of law...." U.S. Const. amend. XIV, § 1. The Clause also includes a substantive component that "provides heightened protection against government interference with certain fundamental rights and liberty interests." *Washington v. Glucksberg*, 521 U.S. 702, 719-20 (1997). "The liberty interest at issue in this case—the interest of parents in the care, custody, and control of their children—is perhaps the oldest of the fundamental liberty interests recognized by this Court." *Troxel v. Granville*,

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530 U.S. 57, 65 (2000); *see also Kanuszewski v. Mich. Dep't of Health and Human Serv's*, 927 F.3d 396, 419 (6th Cir. 2019) ("[P]arents' substantive due process right to make decisions concerning the care, custody, and control of their children includes the right to direct their children's medical care."). Parents are presumed to be acting in the best interest of their children. *Parham v. J.R.,* 442 U.S. 584, 602 (1979).

As the Court has previously found, the Parent Plaintiffs have a fundamental right to seek medical care for their children and, in conjunction with their adolescent child's consent and their doctor's recommendation, make a judgment that medical care is necessary. "[T]the Fourteenth Amendment 'forbids the government to infringe . . . 'fundamental' liberty interests at all, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest.'" *Glucksberg*, 521 U.S. at 721 (quoting *Reno v. Flores*, 507 U.S. 292, 302 (1993)). Strict scrutiny is the appropriate standard of review for infringement of a fundamental parental right. However, even under the heightened scrutiny standard, Act 626 fails.

The State has a compelling interest in "safeguarding the physical and psychological well-being of a minor. . .." *Globe Newspaper Co. v. Superior Ct. for Norfolk Cnty*., 457 U.S. 596, 607 (1982). As explained, the State has failed to present evidence that the gender-affirming procedures banned by Act 626 jeopardize the physical or psychological well-being of a minor with gender dysphoria. There is no evidence that the Arkansas healthcare community is throwing caution to the wind when treating minors with gender dysphoria.

Moreover, the evidence shows that the Arkansas Medical Board has successfully navigated the regulation of the healthcare community in controversial areas such as the

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opioid crisis and gastric bypass surgery. The Arkansas Medical Board is the best option for regulating the ethical considerations as well as the duties of the healthcare community in circumstances like the treatment of gender dysphoria. Plaintiff Parents' testimony at trial confirmed that they have made the decision to get gender-affirming care for their children after discussions with and observations of their child, thorough research, counseling, and consultation with a doctor. They are acting in the best interest of their children. Act 626 would take away these parents' fundamental right to provide healthcare for their children and give that right to the Arkansas Legislature.

Further, Act 626's ban of all gender transition procedures "including without limitation physician's services, inpatient and outpatient hospital services, or prescribed drugs related to gender transition" is not narrowly tailored to achieve the State's articulated interests. Though the State applauds the efforts of European countries to restrict gender-affirming care for minors with gender dysphoria, the State's expert testified that no other country in the world has taken Arkansas's broad stance. None of these countries have imposed a ban on all gender-affirming care.

For these reasons, the Court finds that Act 626 violates the Parent Plaintiffs' rights to substantive due process.

D. First Amendment

Act 626 provides that "[a] physician, or other healthcare professional shall not refer any individual under eighteen (18) years of age to any healthcare professional for gender transition procedures." Ark. Code Ann. § 20-9-1502(b). Dr. Stambough claims that Act 626 restricts her freedom of speech by barring her from referring her patients to other healthcare professionals for gender transition treatment in violation of the First

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Amendment. The State argues that the Act targets conduct, not communication, by healthcare professionals. In support, the State cites to the definition of "referral" on Healthcare.gov. (Defs.' Post-Tr. Br., ECF 265 at 25.). The website defines referral as follows:

> A written order from your primary care doctor or you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

https://www.healthcare.gov/glossary/referral (last visited May 24, 2023).

The State argues that writing an order, or "referring," a patient to another physician for gender transition procedures amounts to a treatment order. A treatment order is professional conduct subject to regulation by the State, even if it incidentally involves speech. The State argues that the Act's purpose is to encourage speech in the form of psychotherapy for treatment of gender dysphoria.

The Court is not persuaded by these arguments. The Act does not define the word "refer." Prosecutors and the Arkansas State Medical Board are unlikely to rely on the Health Insurance Marketplace's website when determining whether a healthcare professional has violated Act 626. Had the Arkansas Legislature intended to bar physicians from writing an order directing a patient to seek gender transition procedures from another provider it could have included that statement in the Act. *See* S.B. 184, ALA. 2022 Reg. Sess. (2022); *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1149 (M.D. Ala. 2022) (Alabama's transgender healthcare ban legislation prohibits the "prescribing or administering" of gender transition treatment which is conduct not speech.).

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As written, Act 626 clearly regulates speech and not conduct as argued by the State. It prevents doctors from informing their patients where gender transition treatment may be available. It effectively bans their ability to speak to patients about these treatments because the physician is not allowed to tell their patient where it is available. "[A] State may not, under the guise of prohibiting professional misconduct, ignore constitutional rights." *Nat'l Ass'n for Advancement of Colored People v. Button*, 371 U.S. 415, 439 (1963); *see also Nat'l Inst. of Fam. & Life Advocs. v. Becerra*, 138 S. Ct. 2361, 2371–72 (2018) ("[T]his Court has not recognized 'professional speech' as a separate category of speech. Speech is not unprotected merely because it is uttered by 'professionals.'").

Act 626 is a content and viewpoint-based regulation of speech because it restricts healthcare professionals from making referrals for "gender transition procedures" only, not for other purposes. As a content and viewpoint-based regulation, it is "presumptively unconstitutional" and is subject to strict scrutiny. *Reed v. Town of Gilbert*, 576 U.S. 155, 163 (2015).

Again, the State explains that it has a compelling interest in keeping children away from gender transition procedures because their efficacy and safety are doubtful. The problem with this argument is that the State has failed to prove that gender-affirming care for minors with gender dysphoria is ineffective or riskier than other medical care provided to minors. The State also contends it has a compelling interest in regulating the ethics of the medical profession. There was no evidence presented that an Arkansas physician or healthcare provider has been ethically compromised in their treatment of adolescents with gender dysphoria or their communication with patients regarding gender

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transitioning procedures. As stated, the Arkansas Medical Board has proven to be an effective regulator of Arkansas healthcare professionals in controversial areas of medicine.

For these reasons, the Court finds that the State has failed to prove that its interests in the safety of Arkansas adolescents from gender transitioning procedures or the medical community's ethical decline are compelling, genuine, or even rational. Act 626 violates Dr. Stambough's rights under the First Amendment.

E. Permanent Injunction

Plaintiffs seek permanent injunctive relief. To obtain a permanent injunction, Plaintiffs were required to "show actual success on the merits." *Miller v.* Thurston, 967 F.3d 727, 735 (8th Cir. 2020). Substantial evidence at trial demonstrated that Act 626 violates Plaintiffs' constitutional rights. Testimony from the Minor Plaintiffs, their parents, Dr. Stambough and the experts proved that they would suffer immediate and irreparable harm from Act 626 if it were to go into effect. This harm to Plaintiffs and the public interest is outweighed by any potential harm to the State of Arkansas caused by the entry of a permanent injunction.

IV. Conclusion

For these reasons, the Court hereby orders that Defendant Tim Griffin, in his official capacity as Attorney General of the State of Arkansas, and all those acting in concert with him, including employees, agents, successors in office, and the members of the Arkansas State Medical Board are permanently enjoined from enforcing House Bill

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1570, Act 626 of the 93rd General Assembly of Arkansas, codified at Ark. Code Ann. §§ 20-9-1501 to 20-9-1504 and 23-79-164. The Clerk is directed to close the case. [14]

IT IS SO ORDERED this 20th day of June, 2023.

James M. Moody Jr.
United States District Judge

[14] The Court retains jurisdiction to consider motions for attorneys' fees.

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From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Tuesday, June 20, 2023 9:39 PM PDT
To: [redacted]@su.edu>
Subject: Re: Gender Affirming Therapy

Hello. Thanks for reaching out and sharing your story. I would suggest looking into the WPATH GEI program.

Best,

Maddie

****
Maddie Deutsch, MD, MPH
Professor of Clinical Family & Community Medicine
Medical Director, UCSF Gender Affirming Health Program
UCSF Health Physician Co-Lead for Diversity, Equity, Inclusion, and Belonging
Co-Director, Differences Matter, UCSF School of Medicine
University of California - San Francisco

President, US Professional Association for Transgender Health

1725 Montgomery St, Suite 250
San Francisco, CA 94111
415-797-7136 phone
415-353-3399 fax
Madeline.Deutsch@ucsf.edu
transcare.ucsf.edu
profiles.ucsf.edu/madeline.deutsch

From: [redacted]@su.edu>
Sent: Monday, June 19, 2023 5:28 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Gender Affirming Therapy

This Message Is From an External Sender
This message came from outside your organization.

Dr. Deutsch,
Hello, and thank you, first and foremost, for all you do for the transgender community!
I am a practitioner and would like to take courses on gender affirmation therapy and treatment, and wanted to reach out to you to ask if you know of any courses for providers? There are not many places in our area (the panhandle of West Virginia/Virginia/Maryland) and many of these patients have to travel hours to a planned parenthood to get hormone therapy. Unfortunateely, many planned parenthoods are closing in this area.
I am a nurse practitioner and would like to help these patients if I could in some way. [redacted]The communities in my area are not as trans-friendly, as I guess you can imagine.
Thank you for any suggestions! I appreciate your time.

[redacted], DNP, APRN, ANP-C, FNP-C (she, her)
Assistant Professor
FNP Program
Shenandoah University

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From: [redacted]@su.edu>
Sent: Wednesday, June 21, 2023 4:44 AM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: Gender Affirming Therapy

This Message Is From an External Sender
This message came from outside your organization.

Thank you so much!

On Wed, Jun 21, 2023 at 12:39 AM Deutsch, Madeline <Madeline.Deutsch@ucsf.edu> wrote:

> Hello. Thanks for reaching out and sharing your story. I would suggest looking into the WPATH GEI program.
>
> Best,
>
> Maddie
>
> **********
> Maddie Deutsch, MD, MPH
> Professor of Clinical Family & Community Medicine
> Medical Director, UCSF Gender Affirming Health Program
> UCSF Health Physician Co-Lead for Diversity, Equity, Inclusion, and Belonging
> Co-Director, Differences Matter, UCSF School of Medicine
> University of California - San Francisco
>
> President, US Professional Association for Transgender Health
>
> 1725 Montgomery St, Suite 250
> San Francisco, CA 94111
> 415-797-7136 phone
> 415-353-3399 fax
> Madeline.Deutsch@ucsf.edu
> transcare.ucsf.edu
> profiles.ucsf.edu/madeline.deutsch
>
> ---
>
> **From:** [redacted]@su.edu>
> **Sent:** Monday, June 19, 2023 5:28 AM
> **To:** Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
> **Subject:** Gender Affirming Therapy
>
> **This Message Is From an External Sender**
> This message came from outside your organization.
>
> Dr. Deutsch,
> Hello, and thank you, first and foremost, for all you do for the transgender community!
> I am a practitioner and would like to take courses on gender affirmation therapy and treatment, and wanted to reach out to you to ask if you know of any courses for providers? There are not many places in our area (the panhandle of West Virginia/Virginia/Maryland) and many of these patients have to travel hours to a planned parenthood to get hormone therapy. Unfortunateely, many planned parenthoods are closing in this area.
> I am a nurse practitioner and would like to help these patients if I could in some way. [redacted] The communities in my area are not as trans-friendly, as I guess you can imagine.
> Thank you for any suggestions! I appreciate your time.
> [redacted]
> [redacted] DNP, APRN, ANP-C, FNP-C (she, her)
> Assistant Professor
> FNP Program
> Shenandoah University

[redacted]
[redacted] DNP, APRN, ANP-C, FNP-C (she, her)
Assistant Professor
FNP Program
Shenandoah University

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Obtained via CPRA by Judicial Watch, Inc.

WHAT IS SCM, ALSO KNOWN AS

MASCULINIZING TOP SURGERY?

Chest masculinization surgery involves the removal of the glandular, fatty tissue of the chest (aka breast tissue), also called a mastectomy.

Different surgical techniques are used to remove tissue from the chest. The determination of surgical technique mostly depends on patent's anatomy. The two most common techniques are:

Double incision: is used for individuals with more tissue and may require two horizontal or one horizontal line across the chest at the pectoral muscle line. The areola and nipples are repositioned (by grafting) and reshaped to create a masculine appearance to the chest.

Periareolar incision, or "Keyhole": can be performed on individuals with less chest tissue; it is a smaller incision in the areolar area and liposuction is used to remove fat tissue. Nipple reshaping and repositioning are not typically performed.

YOU'RE ON YOUR WAY TO BECOMING MORE YOU, AND WE'RE HERE TO HELP.

The mission of Gender Health SF is to increase access to quality gender-affirming health care for underserved transgender and non-binary people in San Francisco, regardless of immigration status and/or lack of income.

NOTES:

sfdph.org/genderhealthsf

genderhealthsf@sfdph.org
(628) 217-5788

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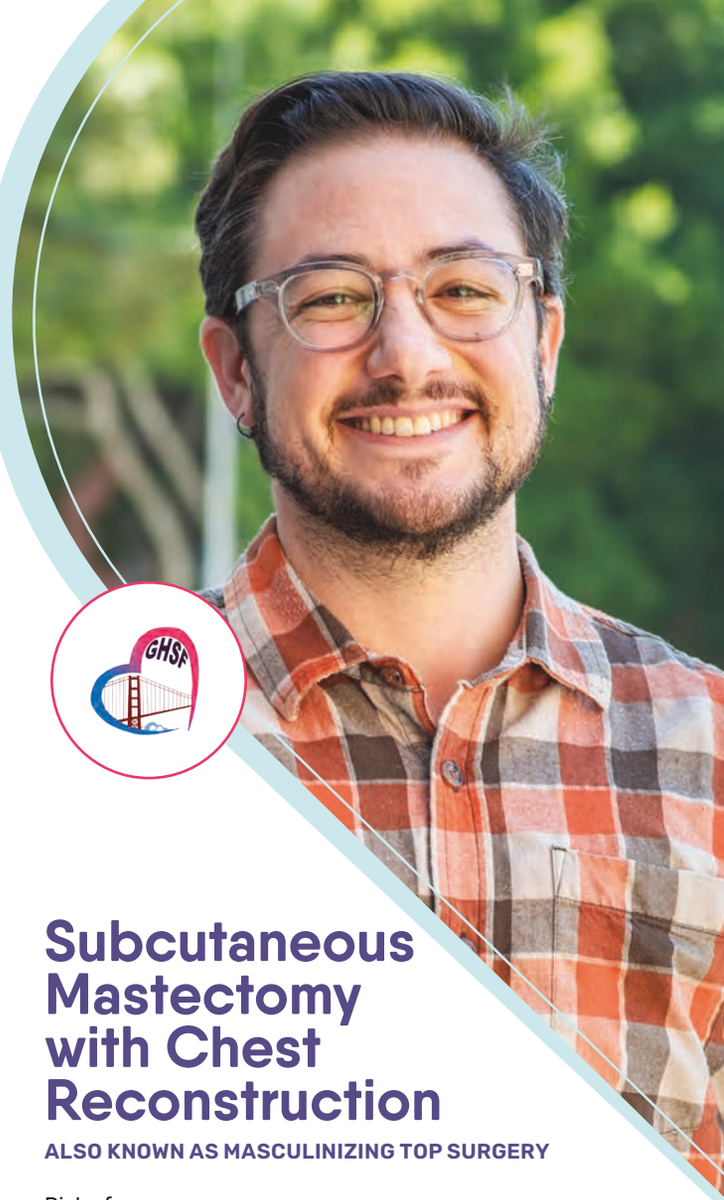

Subcutaneous Mastectomy with Chest Reconstruction

ALSO KNOWN AS MASCULINIZING TOP SURGERY

Risk of surgery
Getting the best results
Questions to ask your surgeon
Possible surgical & non-surgical procedures

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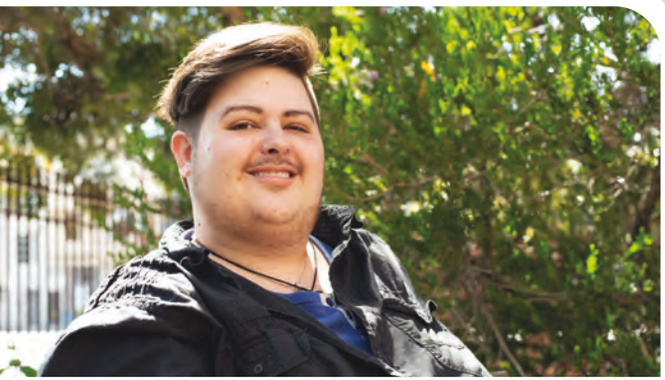

PREPARING FOR SURGICAL CONSULTATION

Your peer navigator can help you prepare for a successful consultation with a surgeon and discuss your desired goals and outcomes prior to consult.

SURGICAL PLAN

Surgical techniques used are based on chest shape and size, skin elasticity, as well as patient's needs and preferences. During your consultation, you and the surgeon will work together to discuss your preferences and determine a surgical plan based on your needs.

NIPPLE SIZE AND SENSATION

Patients will want to discuss nipple size, reshaping, as well as impact on sensation, including erotic sensation, with surgeon during consultation. Patients can choose to completely remove the nipples.

SCARRING

Scarring is a part of surgery. It is important to discuss where incisions will be made and potential impact of scarring on the chest area.

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Preparing For Surgery & Expectations

Your PCP, surgeon, and Gender Health Navigator can help you achieve optimal surgical outcomes by actively preparing for your surgery and making sure expectations are surgically possible.

PHYSICAL HEALTH

Maintain a healthy body weight, high body weight can increase complications and interfere with wound healing. Although there is not a strict Body Mass Index (BMI) requirement, your surgeon may discuss specific anesthesia risks or considerations, depending on your BMI. It is beneficial to reach your own personal sustainable goal weight prior to surgery.

MENTAL HEALTH/WELLNESS

Having surgery takes both physical and mental preparation. Surgery is stressful, some people feel an increase in depression or anxiety after surgery. If you notice any changes in your mood or sleep, especially with anesthesia, please discuss with your care team. If you struggle with mental health, reach out to your mental health provider or navigator for support.

SMOKING

Nicotine intake by smoking, patches, chewing gum, or vaping may interfere with wound healing. If you use nicotine, you should discuss a quit date with your PCP and surgeon. Surgeons require patients to stop nicotine prior to surgery and may test for confirmation.

If you inhale cannabis, it's important to find another way to use it, for example, topical, edibles, and tinctures, or to stop altogether.

SUPPORT

Build your network of support with providers, family, and community to help you plan and organize your recovery prior to and after surgery.

- Transportation to and from appointments
- Meal planning and preparation
- Providing a calm and supportive healing space

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What Can I Expect After Surgery?

Everyone heals differently. Patients will experience—pain, bruising, swelling, and fluid or blood drainage. You will leave the hospital wrapped in a bandage garment on your chest area, it is recommended you keep this on until your 1-week post-op visit. You may need to sleep in specific positions, on your back and slightly elevated for a couple of weeks after surgery.

MOBILITY

After your surgery, you will have less mobility/ability to move and lift your arms. It is important to rearrange your recovery area so that you won't lift or reach for anything above your shoulders during your recovery.

PAIN MANAGEMENT

Ask the doctor what will be provided for pain management. If you have a history of substance use, you may want to talk to your doctor about the safest ways to control pain after surgery.

Aftercare can differ by a patient and depends on the post-op care plan you discuss with your surgeon. For optimal results and to help avoid complications, it is essential to follow all post-op care instructions from your surgeon. Make sure to review the instructions with your navigator and surgeon. The following questions can guide your conversation with your surgeon:

- → What will post-op recovery look like over the course of 3 months?
- → What are recommendations for limiting physical or sexual activity?
- → When can I start to lift or carry heavier items?
- → When can I lift my arms above my shoulders?
- → What impact to my sleeping positions should I expect?
- → How long should I expect to take off from work/school?

! While everything that your surgeon is asking you to do can feel overwhelming, remember that you're not alone. We're in this together. It's okay to reach out to your Gender Health SF navigator for help.

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Becoming more YOU with Gender Health SF

We're ready to partner with you so you can take the next step toward becoming more of the person you know yourself to be. Gender Health SF can help you learn about the kinds of surgeries and procedures that can make your body become more YOU. Whatever decisions you make, just know that you're not alone–you can count on us to be your partner.

YOU'RE ON YOUR WAY TO BECOMING MORE YOU, AND WE'RE HERE TO HELP.

The mission of Gender Health SF is to increase access to quality gender-affirming health care for underserved transgender and non-binary people in San Francisco, regardless of immigration status and/or lack of income.

NOTES:

sfdph.org/genderhealthsf

genderhealthsf@sfdph.org
(628) 217-5788

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Welcome to Gender Health SF

With Gender Health SF as a partner,
you're on your way to becoming more you.

sfdph.org/genderhealthsf

GENDER HEALTH SF
genderhealthsf@sfdph.org • (628) 217-5788

UCSF-DCNF-02429

WHO IS GENDER HEALTH SF?

Gender Health SF was established in April of 2013 by the San Francisco Department of Public Health (SF DPH) to provide access to gender-affirming surgeries and to provide related education and navigational services to transgender, nonbinary, and gender-expansive adults, with an emphasis on uninsured and publicly insured residents of San Francisco. We are a team of peer navigators, public health advocates, mental health, and medical providers committed to the highest quality patient-centered gender-affirming care available. We are a part of your public health department, and we work closely with your primary care provider and care team to help you reach your surgical goals. Our peer-led navigational services are available to referred patients.

PEER-LED NAVIGATION SERVICES INCLUDE:

- Provide resources and information to help a patient reach their surgical goals.
- Provide peer-lead group and one-to-one patient education.
- Offer support with surgeon selection process.
- Teach self-advocacy skills with patients.
- Accompany patients to consultation appointments as needed.
- Engage patients in wellness, such as smoking cessation, mindfulness, and healthy nutrition.
- Care coordination

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Who Is Eligible?

TO QUALIFY FOR THE PROGRAM, YOU MUST BE:

- A resident of San Francisco
- Engaged with primary care at a DPH SF Health Network or Consortium clinic in San Francisco
- Enrolled & covered by Medi-Cal, Medicare, Healthy San Francisco, or have a San Francisco managed Medi-Cal plan—SF Health Plan, Anthem, Healthy Workers, or Healthy Families.

Special consideration is made for patients under age 18

How Can I Be Referred To Gender Health Sf?

A completed referral from your primary care clinic is required to be assigned and provided with navigational services at Gender Health SF. Patients should work with their care team to connect with the appropriate providers who can help you complete the necessary documents.

A complete referral has two main components:

1. A letter of support from a clinician, typically a mental health provider
2. A medical referral from your primary care provider

What Happens Once I Am Referred To Gender Health?

We want to get to know you! Once we receive a completed referral, our clinical team will process your referral, then you will be assigned a navigator. Your navigator will reach out to schedule a short intake, discuss your goals, who your surgeon choices are based on insurance, and next steps. Once we know what surgeon you want to consult with, our team will request approvals from your insurance.

Once approved, our team will send a completed referral to the surgical practices, who will schedule your consultation. Preparing for your consultation with your navigator can yield a more successful and fulfilling consult experience. A navigator can also accompany you to the appointment if desired.

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How Long Will I Have A Navigator?

Navigational services remain in place throughout the consultation and informed consent process with surgeons, to the scheduling and completion of surgeries you have been referred for. Navigators will follow-up with patients during their recovery process, which can extend from 6 months to one-year post-op. Patients may be referred for multiple surgeries; thus, patients will receive navigational services until all surgeries have been completed.

Our Gender Health SF team looks forward to partnering with you in your journey to becoming more YOU!

What Surgeries Do I Have Access To?

Coverage for gender-affirming surgeries depends on your insurances or benefit program. We recommend you discuss your surgical goals and needs with your primary care provider to understand options that are based on your insurance. Your assigned Gender Health navigator can provide additional surgical education for:

- Gender-affirming top surgery
- Gender-affirming facial surgery
- Gender-affirming body contouring
- Orchiectomy
- Hysterectomy & Oophorectomy
- Vaginoplasty & Vulvoplasty
- Metoidioplasty & Phalloplasty
- Hair restoration
- Speech therapy & Vocal Surgery

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From: UpToDate <CE_CustomerSuccess@health.wolterskluwer.com>
Sent: Thursday, June 29, 2023 2:11 AM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: UpToDate Connection – June 2023

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UpToDate Connection

June 2023

At UpToDate®, we are committed to continuous enhancements and innovations — in content, features, and technology — that add meaningful value for you and more than 2 million clinicians worldwide. Check out the most recent enhancements designed to help improve clarity in decision-making and answer your clinical questions quickly.

We encourage you to share these updates with your colleagues.

In this issue:

- COVID-19 public health emergency
- Expanded International Brand Names content
- Graphic algorithms
- Graphics gallery
- Fulfill MATE requirements using UpToDate
- Solving unwarranted variation in care begins with clinical decision-making

UpToDate publishes every business day

UpToDate expert contributors from around the world continuously monitor more than 420 medical journals, so you can trust UpToDate is current. Since the beginning of 2023, 5,855 topics have been updated and 550 new graphics have been added.

Reflecting on the COVID-19 public health emergency

Over 1.8M doctors, nurses, and other clinicians worldwide viewed UpToDate COVID-19 topics more than 52 million times since February 2020. As the COVID-19 public health emergency comes to an end, we reflected on how clinicians utilized UpToDate throughout the pandemic.

Read on to see why clinicians rely on UpToDate as a reliable, global clinical decision support solution — yesterday, today and tomorrow.

Learn More

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Expanded International Brand Names database in drug topics

To help make it easier to verify medicines, accurately prescribe them, and improve patient safety, the *Brand Names: International* field in UpToDate drug topics now includes an enhanced database of international brand names in an easy-to-search functionality.

View Now

Visual algorithms for quick answers to clinical questions

UpToDate continues to expand its inventory of graphic algorithms. About 300 new graphics were added in 2022, with another 300 planned for 2023. Certain clinical questions lend themselves well to graphic algorithms, and the editors at UpToDate strategically add new algorithms to align with clinical questions for which they will make the most impact.

View an Algorithm

Conveniently access topic-relevant graphics

More than 38,000 graphics are available in UpToDate to help support your clinical decisions. Easily discover, scan, and access them using the Graphics Gallery within topics on desktop and mobile. At the top of a topic, select the “Graphics” tab for a convenient view of all relevant graphics.

See it in UpToDate

Fulfill MATE requirements using UpToDate

Continuing education (CE) credits earned from reading certain UpToDate topics will meet the new eight-hour training requirement for Drug Enforcement Administration (DEA)-registered practitioners (per the Medication Access and Training Expansion (MATE) Act)

Please refer to the UpToDate Substance use disorders table of contents for eligible topics.

Learn More

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Solving unwarranted variation in care begins with clinical decision-making

Clinicians face an array of systemic issues and real-time challenges to maintaining standards of care.

Wolters Kluwer's in-depth report, "Solving unwarranted variation in care begins with clinical decision-making," offers insight into the causes of variability and solutions needed to support diagnostic decisions and implement consistent treatment plans across the patient journey.

Download the eBook

Resources

Image

User Academy and Support Knowledge Center

Watch short training videos, review how-to guides, and search common Q&A's.

Explore Now

Image

Mobile App

Get clinical answers on the go on up to two devices.

Download Now

Image

Expert Insights

Get deep domain expertise and information that accelerates decision-making.

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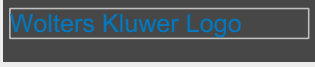

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From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, June 29, 2023 12:09 PM PDT
To: [redacted]@ucsf.edu>
Subject: Fw: Present at UCSF FCM Grand Rounds? - Your Info Needed
Attachment(s): "Headshot 2023.JPG"

Just putting this at the top of your box.

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, June 12, 2023 10:08 PM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds? - Your Info Needed

Hi [redacted] headshot attached.

Title - Caring for Trans and Gender Diverse People - Evidence Based Medicine Across the Lifespan

Summary - Trans and Gender Diverse People need access to quality healthcare. This "Gender Affirming Care" can include medical or surgical care to align one's body with their identified gender, as well as access to a full scope of medical care that is respectful and culturally grounded, and acknowledges gender identities as valid. Recent political developments have added an additional layer of complexity to the barriers to care and disparities faced by this vulnerable population. In this talk, Dr. Deutsch will review current evidence in selected areas of gender affirming care for children, adolescents, and adults of all ages.

Bio - Maddie Deutsch, MD, MPH is a Professor of Clinical Family & Community Medicine at UCSF, and the founding Medical Director for the UCSF Gender Affirming Health Program, a multidisciplinary group of medicine, surgical, and behavioral health providers for trans and gender expansive adults at UCSF Health. She is a Co-Director for the UCSF School of Medicine Differences Matter Initiative, and a DEIB Co-Lead for UCSF Health. Dr. Deutsch has authored or co-authored more than 50 peer reviewed journal articles in the field of sexual and gender minority health, and was a co-author, and Primary Care Chapter Lead, for the recently released WPATH Standards of Care, 8th Version. She is the current President of the US Professional Association for Transgender Health.

Cheers,

Maddie

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, June 12, 2023 11:05 AM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds? - Your Info Needed

Sorry [redacted] I've been really overwhelmed and was on PTO last week. I will get you that by today!

From: J[redacted]@ucsf.edu>
Sent: Monday, June 12, 2023 10:54 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds? - Your Info Needed

It would be great to get the info for your upcoming FCM Grand Rounds posted on the FCM website. Can you send me the info requested below?

Thanks.

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: [redacted]
Sent: Friday, June 2, 2023 5:01 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Hi Maddie,

I'm checking back with you about the info requested below

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Please send me your photo, bio, a title for your presentation, and a brief (paragraph) summary of your presentation.

Thanks.

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, November 21, 2022 1:09 PM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Great, thank you!

From: [redacted]@ucsf.edu>
Sent: Monday, November 21, 2022 12:37 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Great. Thanks, Maddie. You are confirmed for July 7, 2023. Here are some additional details:

About 4-5 weeks out, please send me your photo, bio, a title for your presentation, and a brief (paragraph) summary of your presentation. This will allow me to update our website with your upcoming presentation info and also give me what I need to send out our email invite to our broadcast list. I typically send the email about 3-4 weeks prior and then follow it up with a reminder the week of. Here's where we post the info so you can get a sense of what I'll need: https://fcm.ucsf.edu/family-community-medicine-grand-rounds

Please also send me your presentation materials (slides) a day or two before your event. I put these in a Box folder in case something goes wrong with your screen sharing the day of the presentation. This allows our tech expert, who will be on the webinar, what he'll need to jump in, if necessary.

Also, during the early part of the week of your presentation I will be sending you a specialized individual link for you to use to get on the webinar. This link is different than the generalized link to participants and will allow you to be visible during the webinar. This particular email will come from [redacted]@ucsf.edu as this is the email I use to manage the event. Please make sure to check that it doesn't get captured in any spam folders you may have.

Lastly, we ask presenters to use the specialized link to get on the webinar at 11:30am, 30 minutes prior to start time. This is a time to test your camera, sound, screen share, etc. and tee things up for a successful presentation. Our tech expert will be on the call at that time to iron out any bugs and answer questions. You'll just stay with that same link for when the webinar actually begins at noon.

If you have any questions or concerns, just let me know. We look forward to your upcoming presentation on July 7, 2023.

Thanks.

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, November 21, 2022 12:34 PM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Hi [redacted] et's do July 7. Please let me know when confirmed.

Thanks,

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Maddie

From: [redacted]@ucsf.edu>
Sent: Monday, November 21, 2022 10:05 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Hi Maddie,

For 2023 we have the following dates open:

January 6, 2023
July 7, 2023
August 4, 2023

If none of these work, we'd be moving into 2024. Do any of the above dates work?

Thanks.

[redacted]

[redacted]M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: [redacted]
Sent: Thursday, November 17, 2022 2:58 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Hi Maddie,

I'm waiting to hear back from two people about confirming dates, so once I hear back from them I'll let you know what is available.
Thanks.

[redacted]

[redacted]M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: [redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 12:37 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Huge thanks, Maddie! I am eager to hear your presentation.
Happy Thanksgiving -
[redacted]

[redacted] MD, MPH
Assistant Dean, Undergraduate Medical Education at UC Merced (interim)
Vice Chair of Education, UCSF Department of Family Medicine
Endowed Chair in Community Medicine, Vitamin Settlement Fund
Professor of Clinical Family and Community Medicine
University of California, San Francisco
[redacted]@ucsf.edu

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, November 17, 2022 12:23 PM
To: [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>

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Subject: Re: Present at UCSF FCM Grand Rounds?

Hi [redacted] thanks for the invite, and I am sorry for my delayed reply. I'd be delighted to speak at FCM Grand Rounds. [redacted] please let me know what dates will work. Probably best to look at Feb and beyond.

Cheers,

Maddie

From: [redacted]@ucsf.edu>
Sent: Friday, November 11, 2022 4:33 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Present at UCSF FCM Grand Rounds?

Hi Maddie,
Would you be willing to give FCM Grand Rounds on the role of primary care clinicians in gender affirming care, or gender affirming care in the public health setting, or any related topic that you feel would be a better fit?

As you know, FCM GR focus on themes of health equity and social justice. Your work in gender affirming care seems like it a terrific fit for GR and would be of tremendous interest to our audience, which includes DFCM, 10 affiliated FCM residency sites, DPH primary care, and more.

GR is the first Friday of the month from 12-1pm by zoom. We are scheduling up to a year in advance. Here is a link to recent sessions.
https://fcm.ucsf.edu/family-community-medicine-grand-rounds

If you are willing to present, I will cc [redacted] who can help find a time that works for you.

I hope you are doing well. Thanks for considering!

[redacted]

[redacted] MD, MPH
Assistant Dean, Undergraduate Medical Education at UC Merced (interim)
Vice Chair of Education, UCSF Department of Family Medicine
Endowed Chair in Community Medicine, Vitamin Settlement Fund
Professor of Clinical Family and Community Medicine
University of California, San Francisco
[redacted]@ucsf.edu

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From: [redacted]@ucsf.edu>
Sent: Thursday, June 29, 2023 12:23 PM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds? - Your Info Needed

Thanks!

[redacted] MD, MPH
Assistant Dean, Undergraduate Medical Education at UC Merced (interim)
Vice Chair of Education, UCSF Department of Family Medicine
Endowed Chair in Community Medicine, Vitamin Settlement Fund
Professor of Clinical Family and Community Medicine
University of California, San Francisco
[redacted]@ucsf.edu

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, June 29, 2023 12:09 PM
To: [redacted]@ucsf.edu>
Subject: Fw: Present at UCSF FCM Grand Rounds? - Your Info Needed

Just putting this at the top of your box.

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, June 12, 2023 10:08 PM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds? - Your Info Needed

Hi [redacted], headshot attached.

Title - Caring for Trans and Gender Diverse People - Evidence Based Medicine Across the Lifespan

Summary - Trans and Gender Diverse People need access to quality healthcare. This "Gender Affirming Care" can include medical or surgical care to align one's body with their identified gender, as well as access to a full scope of medical care that is respectful and culturally grounded, and acknowledges gender identities as valid. Recent political developments have added an additional layer of complexity to the barriers to care and disparities faced by this vulnerable population. In this talk, Dr. Deutsch will review current evidence in selected areas of gender affirming care for children, adolescents, and adults of all ages.

Bio - Maddie Deutsch, MD, MPH is a Professor of Clinical Family & Community Medicine at UCSF, and the founding Medical Director for the UCSF Gender Affirming Health Program, a multidisciplinary group of medicine, surgical, and behavioral health providers for trans and gender expansive adults at UCSF Health. She is a Co-Director for the UCSF School of Medicine Differences Matter Initiative, and a DEIB Co-Lead for UCSF Health. Dr. Deutsch has authored or co-authored more than 50 peer reviewed journal articles in the field of sexual and gender minority health, and was a co-author, and Primary Care Chapter Lead, for the recently released WPATH Standards of Care, 8th Version. She is the current President of the US Professional Association for Transgender Health.

Cheers,

Maddie

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, June 12, 2023 11:05 AM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds? - Your Info Needed

Sorry [redacted] I've been really overwhelmed and was on PTO last week. I will get you that by today!

From: [redacted]@ucsf.edu>
Sent: Monday, June 12, 2023 10:54 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds? - Your Info Needed

It would be great to get the info for your upcoming FCM Grand Rounds posted on the FCM website. Can you send me the info requested below?

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Thanks.

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: [redacted]
Sent: Friday, June 2, 2023 5:01 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Hi Maddie,

I'm checking back with you about the info requested below.

Please send me your photo, bio, a title for your presentation, and a brief (paragraph) summary of your presentation.

Thanks.

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, November 21, 2022 1:09 PM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Great, thank you!

From: [redacted]@ucsf.edu>
Sent: Monday, November 21, 2022 12:37 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Great. Thanks, Maddie. You are confirmed for July 7, 2023. Here are some additional details:

About 4-5 weeks out, please send me your photo, bio, a title for your presentation, and a brief (paragraph) summary of your presentation. This will allow me to update our website with your upcoming presentation info and also give me what I need to send out our email invite to our broadcast list. I typically send the email about 3-4 weeks prior and then follow it up with a reminder the week of. Here's where we post the info so you can get a sense of what I'll need: https://fcm.ucsf.edu/family-community-medicine-grand-rounds

Please also send me your presentation materials (slides) a day or two before your event. I put these in a Box folder in case something goes wrong with your screen sharing the day of the presentation. This allows our tech expert, who will be on the webinar, what he'll need to jump in, if necessary.

Also, during the early part of the week of your presentation I will be sending you a specialized individual link for you to use to get on the webinar. This link is different than the generalized link to participants and will allow you to be visible during the webinar. This particular email will come from [redacted]@ucsf.edu as this is the email I use to manage the event. Please make sure to check that it doesn't get captured in any spam folders you may have.

Lastly, we ask presenters to use the specialized link to get on the webinar at 11:30am, 30 minutes prior to start time. This is a time to test your camera, sound, screen share, etc. and tee things up for a successful presentation. Our tech expert will be on the call at that time to iron out any bugs and answer questions. You'll just stay with that same link for when the webinar actually begins at noon.

If you have any questions or concerns, just let me know. We look forward to your upcoming presentation on July 7, 2023.

Thanks.

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

[redacted]

[redacted], M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, November 21, 2022 12:34 PM
To: [redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Hi [redacted], let's do July 7. Please let me know when confirmed.

Thanks,

Maddie

From: [redacted]@ucsf.edu>
Sent: Monday, November 21, 2022 10:05 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Hi Maddie,

For 2023 we have the following dates open:

January 6, 2023
July 7, 2023
August 4, 2023

If none of these work, we'd be moving into 2024. Do any of the above dates work?

Thanks.

[redacted]

[redacted]M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: [redacted]
Sent: Thursday, November 17, 2022 2:58 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: RE: Present at UCSF FCM Grand Rounds?

Hi Maddie,

I'm waiting to hear back from two people about confirming dates, so once I hear back from them I'll let you know what is available.
Thanks.

[redacted]

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: [redacted]@ucsf.edu>
Sent: Thursday, November 17, 2022 12:37 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: [redacted]@ucsf.edu>; J[redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Huge thanks, Maddie! I am eager to hear your presentation.
Happy Thanksgiving -

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Obtained via CPRA by Judicial Watch, Inc.

[redacted]

[redacted] MD, MPH
Assistant Dean, Undergraduate Medical Education at UC Merced (interim)
Vice Chair of Education, UCSF Department of Family Medicine
Endowed Chair in Community Medicine, Vitamin Settlement Fund
Professor of Clinical Family and Community Medicine
University of California, San Francisco
[redacted]@ucsf.edu

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, November 17, 2022 12:23 PM
To: [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; J[redacted]@ucsf.edu>
Subject: Re: Present at UCSF FCM Grand Rounds?

Hi [redacted] thanks for the invite, and I am sorry for my delayed reply. I'd be delighted to speak at FCM Grand Rounds. [redacted] please let me know what dates will work. Probably best to look at Feb and beyond.

Cheers,

Maddie

From: [redacted]@ucsf.edu>
Sent: Friday, November 11, 2022 4:33 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Present at UCSF FCM Grand Rounds?

Hi Maddie,
Would you be willing to give FCM Grand Rounds on the role of primary care clinicians in gender affirming care, or gender affirming care in the public health setting, or any related topic that you feel would be a better fit?

As you know, FCM GR focus on themes of health equity and social justice. Your work in gender affirming care seems like it a terrific fit for GR and would be of tremendous interest to our audience, which includes DFCM, 10 affiliated FCM residency sites, DPH primary care, and more.

GR is the first Friday of the month from 12-1pm by zoom. We are scheduling up to a year in advance. Here is a link to recent sessions.
https://fcm.ucsf.edu/family-community-medicine-grand-rounds

If you are willing to present, I will cc [redacted] who can help find a time that works for you.

I hope you are doing well. Thanks for considering!

[redacted]

[redacted] MD, MPH
Assistant Dean, Undergraduate Medical Education at UC Merced (interim)
Vice Chair of Education, UCSF Department of Family Medicine
Endowed Chair in Community Medicine, Vitamin Settlement Fund
Professor of Clinical Family and Community Medicine
University of California, San Francisco
[redacted]@ucsf.edu

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From: [redacted]@gmail.com>
Sent: Monday, July 03, 2023 7:47 AM PDT
To: [redacted]@gmail.com>
Subject: MUST READ: A Gender Transition Story: How My Views on Medicalization Have Changed Over Time

This Message Is From an External Sender
This message came from outside your organization.

Gender ideology and predatory medicine are ravishing the gay community.

*"I am especially angry at the medical organizations, including **WPATH**, who continue to deny the iatrogenic harms of unfettered gender affirming care practices, while they barely acknowledge the significant psychological and medical needs of detransitioners. I believe medical professionals owe people honesty and that's not happening."*

Open in app or online

A Gender Transition Story: How My Views on Medicalization Have Changed Over Time

Stefan

LGBT COURAGE COALITION

JUL 3

SHARE

Photo by USGS on Unsplash

While gender nonconformity has existed for thousands of years in virtually every culture throughout human history, engaging in medical interventions to 'treat' it is a relatively new phenomenon. The first gender-related surgeries that we know of occurred in the early 20th century. Almost 100 years later, much has changed in the cultural landscape as far as our understanding of gender goes.

Thanks for reading LGBT Courage Coalition !
Subscribe for free to receive new posts and support my work.

Pledge your support

In January 2004, I started hormone treatment to transition from a woman to a

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man. I was a young adult in my mid-20s, living in a large Canadian city, when I embarked on a medical path. My last surgical intervention was in 2010. Over the years, taking testosterone has masculinized my body to the point where I'm visually indistinguishable from men in day-to-day life. Legally, and socially, I'm treated as a man.

My physical transition was relatively straightforward, though I experienced surgical complications along the way. Psychologically and socially, however, I have had a variety of challenges. When I initially embarked on my gender transition from female to male, I was working with a psychiatrist. I had suffered from anxiety and clinical depression for as long as I could remember, and success in therapy remained elusive. I remember the first time I raised the issue of gender transition. Despite a deep anxiety about speaking about anything related to sex or sexuality, I told her that I was thinking maybe I was a man. I recall her being supportive, suggesting that I explore social transition; she even agreed to write a referral letter to a psychologist who specialized in gender dysphoria for a formal assessment.

I saw the assessing psychologist for a single 90 minute session. The natural next step was hormones and surgery. That was the only treatment option that was presented to me. Armed with my assessment letter and a referral to an endocrinologist, I pursued hormone therapy. The long and arduous journey of medical, social and legal gender transition was underway.

In the early days of my transition, I experienced what some call gender euphoria. Taking my first hormone shot felt very empowering. I felt like I was taking control of my own identity, my own destiny. Initially, my depression lifted, my anxiety subsided. A clear path lay ahead of me: updating legal documents, informing loved ones, and looking into surgical options. It gave me a sense of purpose and direction. I built my life around moving forward with my gender transition, which included finding employment that would provide me with health benefits for when I would be recovering from surgeries.

While my life seemed to be going well from how things looked on the outside, not everything was coming together as I'd hoped. Doubts surfaced almost as early as the decision to transition itself, though they were faint at first. I felt a general sense of cognitive dissonance with having to change my body to feel at home in my skin. That dissonance became louder with time. At first, I attributed my reservations to internalized transphobia, the deep self-loathing a trans person harbors toward their difference. I tried to shake it off by clinging to the belief that everyone saw me as male and therefore it must be true. I also told myself that the medical professionals knew what they were doing, that they had my best interests in mind, and that I'd done enough research to suggest these feelings were part of the process of adjusting to who I was really meant to be.

But I had flashes of memories I couldn't deny — moments where I had made choices, not based on the belief that I was a man, but rather on the belief that I was not much of a woman. I recalled moments where I had felt uncomfortable because I didn't like the look of my breasts, or was grossed

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out by my period, or didn't feel like I had much in common with the women around me. I remembered an incident where I exposed my newly articulated transgender identity to a trusted professor. He didn't immediately affirm me. Instead, upon learning about my history of gender nonconformity, he suggested that I had much to talk about with a therapist before making the decision to transition. At the time I resented how cautious he came off. Ensconced in the faith that transition would cure my ills, I didn't approach him again.

After my transition, and as I matured, the desire to have children snuck up on me. Prior to that, I had not allowed myself to imagine the possibility of being a parent. Up to then, I had little concept of growing old, let alone growing old as a man. For much of my teen years and early twenties, I had held a belief that I would be dead by the age of thirty, either by my own hand or by some act outside of my control. As thirty came and went, however, and I continued to live, my views changed — and with it my perspective on my transition.

I no longer consider myself male, though legally that is what I am. When I first transitioned, I thought that gender transition was a cure for my depression and anxiety. Some might say that this was a foolish assumption on my part, and that I am solely responsible for holding it. But this belief didn't come out of nowhere. This is what I was told. What responsibility do the medical providers and psychological assessors have, considering that they had a duty of care and I believed what they were telling me?

Medical transition is held up as a very effective treatment for gender dysphoria. Doctors routinely claim that the regret rate is much lower for this type of intervention than virtually any other medical treatment people receive for other conditions. While I wish that were true, I remain skeptical. No one who helped me along my medical transition ever followed up with me to find out how I was adjusting. Just because people don't necessarily detransition doesn't mean they don't grieve or regret. And what of the rising voices of detransitioners? Do their voices not also matter? Perhaps for some people transition is the right choice and it really is that simple. But for me, my transition has raised more questions than it has answered. I see value in acknowledging these complexities.

As for my gender dysphoria, I still experience it. Only now it's in reverse. Medical transition has complicated my already messy relationship with my body. I mostly like myself when I look in the mirror and see my bearded face, but I also miss the thick, curly brown hair I had as a girl, that at times I wore in a ponytail and sometimes cut short. These days I wear a hat to conceal the hair loss that often accompanies testosterone treatment. I don't mind my deep voice, but I miss my singing voice, the voice my late father loved to hear when I sang carefree in the shower as a teen. I have grown to like the silhouette of my flat, masculinized chest, but I regret the scars and grieve the loss of sensation that followed the loss of a nipple during surgery. I like that I no longer must worry about monthly periods or have to fear unwanted pregnancy, but I experience deep sadness for the child I'll never bear.

Was my medical transition worth it? I'm not so sure.

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Over the years I have had many theories on what led me to transition. Is my gender dysphoria better understood as an anxiety disorder, the fear of becoming an adult woman in a culture hostile to gender nonconformity? Was it social influence and an obsessive disposition that led me down this path? Am I autistic and mistook my sensory sensitivities and communication difficulties for gender dysphoria? Did my misattunement with my mother drive me to over-identify with my father? I'll likely never know.

Regardless, I am bothered by those who would deny that regret — or more accurately, profound grief —happens when we medicalize gender nonconformity, as if it is no big deal. Or, if they do acknowledge that regret happens, they often frame it as irrelevant, or a rare event — a message I've seen promoted by irresponsible healthcare professionals, so-called allies, and even in some LGBT circles. I am especially angry at the medical organizations, including WPATH, who continue to deny the iatrogenic harms of unfettered gender affirming care practices, while they barely acknowledge the significant psychological and medical needs of detransitioners. I believe medical professionals owe people honesty and that's not happening.

It is not hateful to acknowledge the difficulties, the complexities, the challenges, and the inherent contradictions.

Stefan *is a trans man who lives in Canada. He is seeking to build support services for detransitioners and those who feel they were harmed by gender-related medicine. You can find him online at* ***gendercrossroads.org*** *or subscribe to his Substack at* ***gendercrossroads.substack.com***

Add your voice to the dialogue. Send your submissions to lgbtcouragecoalition@gmail.com

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From: [redacted]@ucsf.edu>
Sent: Wednesday, July 05, 2023 12:30 PM PDT
To: [redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: REMINDER: UCSF FCM Grand Rounds - Caring for Trans and Gender Diverse People - Evidence Based Medicine Across the Lifespan - with Dr. Maddie Deutsch - Friday, July 7 at noon

Just a quick reminder about the upcoming FCM Grand Rounds this Friday at noon….

UCSF FCM Grand Rounds

Caring for Trans and Gender Diverse People - Evidence Based Medicine Across the Lifespan

Friday, July 7, 2023
12:00-12:50pm by webinar

https://ucsf.zoom.us/j/[redacted]

Maddie Deutsch, MD, MPH

Trans and Gender Diverse People need access to quality healthcare. This "Gender Affirming Care" can include medical or surgical care to align one's body with their identified gender, as well as access to a full scope of medical care that is respectful and culturally grounded, and acknowledges gender identities as valid. Recent political developments have added an additional layer of complexity to the barriers to care and disparities faced by this vulnerable population. In this talk, Dr. Deutsch will review current evidence in selected areas of gender affirming care for children, adolescents, and adults of all ages.

Maddie Deutsch, MD, MPH is a Professor of Clinical Family & Community Medicine at UCSF, and the founding Medical Director for the UCSF Gender Affirming Health Program, a multidisciplinary group of medicine, surgical, and behavioral health providers for trans and gender expansive adults at UCSF Health. She is a Co-Director for the UCSF School of Medicine Differences Matter Initiative, and a DEIB Co-Lead for UCSF Health. Dr. Deutsch has authored or co-authored more than 50 peer reviewed journal articles in the field of sexual and gender minority health, and was a co-author, and Primary Care Chapter Lead, for the recently released WPATH Standards of Care, 8th Version. She is the current President of the US Professional Association for Transgender Health.

Join by webinar:
Friday, July 7, 2023 from noon-12:50pm
https://ucsf.zoom.us/j[redacted]
Webinar ID: [redacted]
Passcode: [redacted]

Thanks to everyone who joined us for prior FCMGrand Rounds in 2021-2023!

June 2, 2023 – Dr. Kevin Fiscella -Why Defining Health Is Radical: Implications for Health Equity, Value, and National

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Health
May 5, 2023 – Dr. Martin Shapiro - The Present Illness: American Health Care and Its Intractable Afflictions
April 7, 2023 – Dr. Megan Mahoney – Demoralization in Medicine with a Focus on Strategies and Solutions
March 3, 2023 – Dr. Michael Fine - What is Medicine For? - Reflections from On Medicine as Colonialism
February 3, 2023 – Dr. Hillary Kunins -San Francisco's Approach to Improving Behavioral Health Services
December 2, 2022 – Dr. Kevin Grumbach, Pilar Collins & Tasha Toliver - An Equity First Paradigm for Health Care: Hard Earned Lessons from the UCSF Health Response to COVID
November 4, 2022 - Ana Delgado, Ji Seon Song, Nida Bajwa, Norman Archer, Jake Sonnenberg, Kelley Butler -Safety for All and Care without Criminalization: A DPH Must Divest Intro to Patient Rights
October 7, 2022 – Dr. Meghan O'Brien - From Eggshells to Action: Preparing to Address Microaggressions Targeting Learners
September 2, 2022 – Dr. Ayanna Bennett – "Moving from Intention to Action on Health Equity"
June 3, 2022 – Daniel Dawes, J.D. – "The Political Determinants of Health: Advocating for Equitable Health Outcomes"
May 6, 2022 – Dr. Maura Jones, Dr. Deb Borne, & Dr. Jack [redacted] – "Anti-coercion Ethics and the Avoidance of Medical Harm: A Case-based Discussion"
April 1, 2022 - Dr. Ron Goldschmidt, Brenda Goldhammer, Dr. Betty Dong, Dr. Christine Pecci, Dr. Carolyn Chu – "The National Clinician Consultation Center: 30 years (and counting) of tele-consultation for provider capacity-building and public health service"
March 4, 2022 - Nazineen Kandahari & Nilufar Kayhani – "Afghan Clinic: Barriers to Health for Afghan Refugees & How We Can Address Them"
February 4, 2022 – Dr. Christine Dehlendorf, Dr. Lealah Pollock, & Dr. Montida Fleming – "Family Medicine and Abortion: Responding to the Evolving Crisis in Access to Reproductive Health Care"
January 7, 2022 – Dr. Garen Wintemute – "Firearm Violence: Where We Stand, What We Can Do"
December 3, 2021 – Dr. Shira Shavit & Joe Calderon, CHW – "Who We Hire Matters: How Health Systems Address Structural Racism Through Hiring People with Histories of Incarceration"
November 5, 2021 – Dr. Saul Weiner – "Contextualizing Care: An Essential and Measurable Clinical Competency"
October 1, 2021 – Dr. Emilia De Marchis, Dr. Matt Pantell, & Dr. Caroline Fichtenberg – "Should we screen for and document social risk in health care settings?"
September 3, 2021 – Dr. Sundeep Gupta & Professor AddressMauakowa Malata, PhD – "Redefining Global Health through Structural Competency and Allyship"
August 6, 2021 – Dr. Tricia Elliott – "Addressing Racism and Advancing Health Equity In and Beyond the Exam Room"
June 4, 2021 – Dr. Ina Park – *"Strange Bedfellows: Adventures in the Science, History, and Surprising Secrets of STDs."*
May 7, 2021 – Dr. Rita Hamad - "Social Policies to Address Health Inequities: Harder Than It Looks"
April 2, 2021 - UCSF faculty, staff, and community partners - STOP COVID-19 CA Project- "Achieving Racial and Ethnic Equity in COVID-19 Vaccination: Learnings from Community Based Participatory Research."
March 5, 2021 - Dr. Kevin Grumbach and Dr. Juliana Morris - *"The Lancet Commission: Health and Health Policy in the Trump Administration"*

Did you miss them?
Watch most session recordings in our playlist:
[redacted]

Want to share your feedback?
Please fill out an evaluation:
[redacted]

Have suggestions for future FCM Grand Rounds topics or speakers?
Please share your ideas:
[redacted]

Hope you can join us on July 7th!

[redacted]

[redacted] MD, MPH
Assistant Dean, Undergraduate Medical Education at UC Merced (interim)
Vice Chair of Education, UCSF Department of Family Medicine
Endowed Chair in Community Medicine, Vitamin Settlement Fund
Professor of Clinical Family and Community Medicine
University of California, San Francisco
[redacted]@ucsf.edu

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[redacted], M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: [redacted]@ucsf.edu>
Sent: Thursday, July 06, 2023 8:49 AM PDT
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
CC: [redacted]@ucsf.edu>
Subject: RE: REMINDER: UCSF FCM Grand Rounds - Caring for Trans and Gender Diverse People - Evidence Based Medicine Across the Lifespan - with Dr. Maddie Deutsch - Friday, July 7 at noon

Thanks [redacted] for sending out the reminder about the grand rounds presentation, featuring our esteemed colleague Maddie Deutsch. Given the recent political developments that have introduced a new level of barriers to care and disparities faced by Trans and Gender Diverse People, I hope many of us will be able to join this enlightening session tomorrow at noon.

From: [redacted]@ucsf.edu>
Sent: Wednesday, July 5, 2023 12:31 PM
To: [redacted]@ucsf.edu>
Cc: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: REMINDER: UCSF FCM Grand Rounds - Caring for Trans and Gender Diverse People - Evidence Based Medicine Across the Lifespan - with Dr. Maddie Deutsch - Friday, July 7 at noon

Just a quick reminder about the upcoming FCM Grand Rounds this Friday at noon….

UCSF FCM Grand Rounds

Caring for Trans and Gender Diverse People - Evidence Based Medicine Across the Lifespan

Friday, July 7, 2023
12:00-12:50pm by webinar

https://ucsf.zoom.us/j/[redacted]

Maddie Deutsch, MD, MPH

Trans and Gender Diverse People need access to quality healthcare. This "Gender Affirming Care" can include medical or surgical care to align one's body with their identified gender, as well as access to a full scope of medical care that is respectful and culturally grounded, and acknowledges gender identities as valid. Recent political developments have added an additional layer of complexity to the barriers to care and disparities faced by this vulnerable population. In this talk, Dr. Deutsch will review current evidence in selected areas of gender affirming care for children, adolescents, and adults of all ages.

Maddie Deutsch, MD, MPH is a Professor of Clinical Family & Community Medicine at UCSF, and the founding Medical Director for the UCSF Gender Affirming Health Program, a multidisciplinary group of medicine, surgical, and behavioral health providers for trans and gender expansive adults at UCSF Health. She is a Co-Director for the UCSF School of Medicine Differences Matter Initiative, and a DEIB Co-Lead for UCSF Health. Dr. Deutsch has authored or co-authored more than 50 peer reviewed journal articles in the field of sexual and gender minority health, and was a co-author, and Primary Care Chapter Lead, for the recently released WPATH Standards of Care, 8th Version. She is the current President of the US Professional Association for Transgender Health.

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Join by webinar:
Friday, July 7, 2023 from noon-12:50pm
https://ucsf.zoom.us/j/[redacted]
Webinar ID: [redacted]
Passcode: [redacted]

Thanks to everyone who joined us for prior FCMGrand Rounds in 2021-2023!

June 2, 2023 – Dr. Kevin Fiscella -Why Defining Health Is Radical: Implications for Health Equity, Value, and National Health
May 5, 2023 – Dr. Martin Shapiro - The Present Illness: American Health Care and Its Intractable Afflictions
April 7, 2023 – Dr. Megan Mahoney – Demoralization in Medicine with a Focus on Strategies and Solutions
March 3, 2023 – Dr. Michael Fine - What is Medicine For? - Reflections from On Medicine as Colonialism
February 3, 2023 – Dr. Hillary Kunins -San Francisco's Approach to Improving Behavioral Health Services
December 2, 2022 – Dr. Kevin Grumbach, Pilar Collins & Tasha Toliver - An Equity First Paradigm for Health Care: Hard Earned Lessons from the UCSF Health Response to COVID
November 4, 2022 - Ana Delgado, Ji Seon Song, Nida Bajwa, Norman Archer, Jake Sonnenberg, Kelley Butler -Safety for All and Care without Criminalization: A DPH Must Divest Intro to Patient Rights
October 7, 2022 – Dr. Meghan O'Brien - From Eggshells to Action: Preparing to Address Microaggressions Targeting Learners
September 2, 2022 – Dr. Ayanna Bennett – "Moving from Intention to Action on Health Equity"
June 3, 2022 – Daniel Dawes, J.D. – "The Political Determinants of Health: Advocating for Equitable Health Outcomes"
May 6, 2022 – Dr. Maura Jones, Dr. Deb Borne, & Dr. Jack [redacted] – "Anti-coercion Ethics and the Avoidance of Medical Harm: A Case-based Discussion"
April 1, 2022 - Dr. Ron Goldschmidt, Brenda Goldhammer, Dr. Betty Dong, Dr. Christine Pecci, Dr. Carolyn Chu – "The National Clinician Consultation Center: 30 years (and counting) of tele-consultation for provider capacity-building and public health service"
March 4, 2022 - Nazineen Kandahari & Nilufar Kayhani – "Afghan Clinic: Barriers to Health for Afghan Refugees & How We Can Address Them"
February 4, 2022 – Dr. Christine Dehlendorf, Dr. Lealah Pollock, & Dr. Montida Fleming – Family Medicine and Abortion: Responding to the Evolving Crisis in Access to Reproductive Health Care"
January 7, 2022 – Dr. Garen Wintemute – Firearm Violence: Where We Stand, What We Can Do"
December 3, 2021 – Dr. Shira Shavit & Joe Calderon, CHW – Who We Hire Matters: How Health Systems Address Structural Racism Through Hiring People with Histories of Incarceration"
November 5, 2021 – Dr. Saul Weiner – 'Contextualizing Care: An Essential and Measurable Clinical Competency"
October 1, 2021 – Dr. Emilia De Marchis, Dr. Matt Pantell, & Dr. Caroline Fichtenberg – Should we screen for and document social risk in health care settings?"
September 3, 2021 – Dr. Sundeep Gupta & Professor AddressMauakowa Malata, PhD – "Redefining Global Health through Structural Competency and Allyship"
August 6, 2021 – Dr. Tricia Elliott – 'Addressing Racism and Advancing Health Equity In and Beyond the Exam Room"
June 4, 2021 – Dr. Ina Park – *'Strange Bedfellows: Adventures in the Science, History, and Surprising Secrets of STDs."*
May 7, 2021 – Dr. Rita Hamad -"Social Policies to Address Health Inequities: Harder Than It Looks"
April 2, 2021 - UCSF faculty, staff, and community partners - STOP COVID-19 CA Project- "Achieving Racial and Ethnic Equity in COVID-19 Vaccination: Learnings from Community Based Participatory Research."
March 5, 2021 - Dr. Kevin Grumbach and Dr. Juliana Morris - *'The Lancet Commission: Health and Health Policy in the Trump Administration"*

Did you miss them?
Watch most session recordings in our playlist:
[redacted]

Want to share your feedback?
Please fill out an evaluation:
[redacted]

Have suggestions for future FCM Grand Rounds topics or speakers?
Please share your ideas:
[redacted]

Hope you can join us on July 7th!

[redacted]

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[redacted] MD, MPH
Assistant Dean, Undergraduate Medical Education at UC Merced (interim)
Vice Chair of Education, UCSF Department of Family Medicine
Endowed Chair in Community Medicine, Vitamin Settlement Fund
Professor of Clinical Family and Community Medicine
University of California, San Francisco
[redacted]@ucsf.edu

[redacted] M.A. | Student Programs Manager | UCSF | Dept. of Family & Community Medicine
[redacted]@ucsf.edu | https://fcm.ucsf.edu/

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From: [redacted]@gmail.com>
Sent: Tuesday, July 11, 2023 4:53 AM PDT
To: [redacted]@gmail.com>
Subject: MUST READ I am a transman

This Message Is From an External Sender
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I am a transman

I was kicked out of WPATH's Science Symposium for Wrongthink

LGBT COURAGE COALITION AND AARON TERRELL
JUL 11

SHARE

I am a transgender man who works with an organization called Gender Dysphoria Alliance (GDA). Our intention is to clear away the vitriol and misinformation coming from all sides of the proverbial isle by highlighting the condition that motivates medical transition: Gender Dysphoria. It was in this capacity that I virtually attended the World Professional Association of Transgender Health's (WPATH) Biannual Scientific Symposium, where they happened to be introducing their latest Standards of Care (SoC 8); the document that is intended to guide clinicians in treating children and adults presenting with gender dysphoria.

I had two primary intentions in attending the conference. The first was to gain a better understanding of the recently released SoC 8, which I had already read and had many reservations about. The second, more important, was to network with providers within WPATH who might have similar aims to GDA's. However, the more presentations I attended, the more concerned I became with WPATH's internal culture. The theme of the language used in the presentations and from audience questions was that of righteousness and persecution, not medicine and scientific inquiry. Even in a presentation on medical interventions for children who identify as 'nonbinary' and 'genderqueer', including hormone treatment and surgeries to solidify those identities, the only questions asked of the presenters was not about the existence of studies that demonstrate the health benefits of such treatment, but rather how to get 'transphobic parents' to agree to the interventions.

As I was attending virtually, the only way for me to interact with other conference goers or presenters was via the chat and forum functions within the virtual platform. Attendees were encouraged to participate in various affinity group forums or start new threads on topics of interest. On the second-to-last day I introduced myself in a forum called 'trans attendees'. I said, "Hi all! I am a trans man and representative of the Gender Dysphoria

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Alliance - an international organization that advocates for better mental health care for gender dysphoric people and more robust research into the medical interventions offered to us." This post received one laughing emoji.

Thanks for reading LGBT Courage Coalition !
Subscribe for free to receive new posts and support my work.

Pledge your support

The following are transcriptions of the rest of the replies I received. Be aware, most of the participants are WPATH member providers, specifically in the mental health field. I am not going to introduce or name the individuals commenting, and will only indicate when I chime in. I have included the emoji responses to each reply because I feel it helps give the sense of the community consensus.

The first reply was, "For those unaware, the Gender Dysphoria Alliance promotes links to anti-trans, pro-conversion-therapy organizations. Detrans/retrans people deserve better than such organizations, and cis attendees should be aware the above post is not an accurate reflection of their mission." This message received 12 thumbs up.

I replied, "I am sorry [name] but that is false. GDA is 100% opposed to conversion therapy and I have not misrepresented the mission of the org. Why would I do that? Anyone is welcome to see what we are about. [linked to website]"

The next response read, "yall GDA is an anti trans hate group. Aaron, happy to have a professional discussion offline if this is a conversation you're actually interested in having." This message received five thumbs up and two hearts.

"The first point on their website is "inform the conversation about GD" which leads straight to "there are different types of gd (e.g. HSTS, AGP, ROGD, DSD-related)..." Autogynephilia has been as debunked as anything in mental health can be. Rapid Onset Gender Dysphoria is a political construct that as best as I can tell means either "My kid came out as trans and I don't like it" or "I'm not a good enough parent to have realized what was going on with my kid and now I'm sad." The ROGD community in both cases would punish the kid. Any group that acknowledges either of those two theories about transgender people deserves to be shouted down in any group of science-based practitioners of physical and mental health." Three thumbs up.

"I take great reservation for any organization that affiliates with Ray Blanchard or Lisa Littman, let alone champions them as contributors to their Advisory Board. Their publications have caused harm to trans people globally

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by fundamentally misrepresenting the lived experiences of trans people with relative impunity." One thumbs up.

I chimed back in, "Our aim is to understand gender dysphoria - what causes it, how best to treat it. Understanding the different types of gender dysphoria is fundamental to this end. I have found the trans community at large is uninterested in the details of GD, which I think is doing us harm long term."

"These are TERF talking points. No trans folks are 'denying the realities of biological sex.'" Four thumbs up.

"Do you believe we also need to look for explanations as to why some people are (cis) male or (cis) female? Or do you believe they are self-evident? Does an explanation benefit individual members of the community? Or does it simply provide some reassurance around validity to those who do not have trans identities?" Five thumbs up.

"If your answers to these are difficult for you, or seem to move away from that of the majority of the community, it may be worth reflecting on your own experiences with and reactions to cisnormativity." Nine thumbs up, four hearts.

"Aaron Terrell I hope you are not being disingenuous here. Giving the benefit of the doubt, there is nothing wrong with investigating gender dysphoria. But any scientific investigation of necessity starts with an unbiased mind and with clear criteria for validating or disproving hypotheses. In particular, Blanchard's autogynephilia stuff has been examined already and has been universally rejected by serious mental health researchers, providers, and overwhelmingly by trans people's experience. He fundamentally misunderstands so many things about trans experience. Without anything new from him, considering his reasons for gender dysphoria is roughly equivalent to considering whether or not the earth really is round. We just know better." Eight thumbs ups.

"GDA is a hate group hiding behind a "scientific" veneer and this organization's publications are cited as reasons to deny gender affirming care by transphobic politicians. I hope you realize the harm spreading discredited science does to our community both on a medical and political level." Six hearts.

"'Biological sex' or more accurately sexual development based on chromosomes, hormones and are more realistically described in a variety of bimodal spectrums so I refute the mainstream endonormative view of sex which I am confident this group also endorses." Two thumbs up. Eight hearts.

"I would advise against attempting to educate groups with an established pattern in this area and in this forum. We have nothing to gain. Meanwhile you just help them consider counter arguments to misinformation they were considering spreading, and allow them to refine their arguments to be more difficult to challenge."

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"In general, I completely agree. But since Aaron Terrell identifies as trans themself, I was open to the possibility that they might be individually open to considering better science. If they are some sort of infiltrator, then you're absolutely right. I wasn't sure how to determine that."

"His bio states he is "co-founder" of the GDA, which given just their openly stated mission statements, concerns me."

"Folks please keep in mind there may be people registered for this conference and accessing this app/chat to screenshot things out of context and share on wider social media. If someone from GDA is here, there may be even folks from even more heinous organizations watching this forum. WPATH does not audit attendees for accreditation or reputability of the organization they represent." Three hearts.

Me again, "I am 100% genuine and co-host a podcast discussing the various types of GD where we host individuals who share their own experiences with those different types. It's called Transparency and can be accessed on whichever podcast platform you prefer and also video versions on YouTube. Blanchard's theories have not been debunked despite so many claims that they have- researchers just stopped asking the questions about it and instead just accept a concept of innate gender identity- when there is no actual evidence to support that. If you can point me to research that better explains male to female GD I would be more than happy to review it."

"Y'all it might be best to just not engage." Two thumbs up. Seven hearts.

They heeded the above advice and the flow of replies, which had been rapid fire, stopped. Around this point I left to run an errand and about an hour later I tried to access the conference via the app instead of my desktop and found I was no longer registered for the conference. I assumed this was an issue with the app and not my registration, but when I got home to my desktop, the browser I had been logged in on also showed I wasn't registered. I emailed an administrator at WPATH who quickly replied telling me she had 'reset' my login and to try again. That did the trick and I was back in the conference, though I was half concerned I was intentionally removed due to the earlier discussion. I watched the rest of the day's presentations and refrained from using the discussion platform.

On the last day of the conference I started a thread (as attendees were encouraged to do), in a last ditch attempt to make contact with anyone within WPATH who might ally with GDA. The platform encouraged the thread writer to give a title, a description, and then ask the first question to kick off the conversation. My thread read as follows:

Title: Trans individuals concerned with affirmation only approach

Description: I am a transgender adult who is concerned by the rapid medicalization of gender diverse children and young people. I am with Gender Dysphoria Alliance- an organization of adults with experiences of gender dysphoria advocating for safe and holistic care for trans and gender nonconforming people. Please see www.genderdysphoriaalliance.com for

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more information.

Question: What are clinicians doing to ensure gender nonconforming cis children and adolescents aren't transitioning unnecessarily?

I expected to get slammed in the comments in a similar fashion I had the day prior, but I was hoping people might reach out privately via the private message function. What actually happened was I was unenrolled in the conference within minutes of posting the above thread. I was not formally notified of my expulsion, nor given a warning regarding any potentially inappropriate conduct on my part. Rather, when I returned to check if there were any replies to my thread, I was taken to the homepage of the platform that told me I was not currently registered for any conferences.

I do know it was that thread that resulted in my removal because the app that hosted the conference had an advantageous glitch that allowed me to see what was being discussed despite no longer being registered. That is, I continued to receive notifications of messages, but when I clicked to open them I was taken to the screen that said I wasn't registered. I screenshot those notifications and then later looked up the people commenting. I am again not including Their names, but in this case I am including their job descriptions.

Clinical Director of Transgender and Intersex Specialty Care Clinic at Mayo Clinic Florida: "hi all, back again to call GDA out as an anti-trans hate group. Please see the trans attendees thread for discussion."

Registered Social Worker, Psychotherapist - Family Therapy, Crisis Management, DBT, DDP, and Gender Affirming Therapy. 2S-LGBTQIA Health Educator. WPATH Clinician: "Hi look! They're back to stir the pot! Do not engage with this thread or individual. They are part of a TERF led anti trans hate group focused on…"

The same WPATH Clinician moments later: "Just wanted to bring attention to the fact another TERF and member of the gender dysphoria alliance keeps trying to make threads and…"

[I had not made any other threads]

Doctoral Student at Brown University School of Public Health: "Hi [above WPATH Clinician]. Please report any of these threads to the registration desk so they can review and take action."

WPATH Clinician: "The individual is Aaron Terrell"

Doctoral Student at Brown: "Hi [WPATH Clinician]. Aaron was removed from the platform earlier this morning. I've also gone in to delete the discussion topic that was posted."

Thirty minutes later:

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Clinical Director of Transgender and Intersex Specialty Care Clinic at Mayo Clinic Florida: “can we please get this removed?”

Clinical Director of Transgender and Intersex Specialty Care Clinic at Mayo Clinic Florida: [sent a new photo]

Clinical Director of Transgender and Intersex Specialty Care Clinic at Mayo Clinic Florida: @[Doctoral student at Brown], I’m still seeing the thread.

Fifteen minutes later:

Associate Professor of Psychiatry at Yale School of Medicine: “organizers, please take this thread off [tags two administrators]”

These appeals for the thread to be removed stopped appearing on my phone, so I assume their pleas were finally headed.

Just read again the words I wrote that multiple WPATH health professionals were so deeply offended by,

Title: Trans individuals concerned with affirmation only approach

Description: I am a transgender adult who is concerned by the rapid medicalization of gender diverse children and young people. I am with Gender Dysphoria Alliance- an organization of adults with experiences of gender dysphoria advocating for safe and holistic care for trans and gender nonconforming people. Please see www.genderdysphoriaalliance.com for more information.

Question: What are clinicians doing to ensure gender nonconforming cis children and adolescents aren’t transitioning unnecessarily?

It is clear the clinicians and researchers who wrote the SoC not only do not have an answer to that simple and reasonable question, they are appalled that anyone would even ask it.

Myself and GDA’s director have sent multiple emails to WPATH’s registration office asking for either a reason for my eviction or the $725 registration fee refunded. It was on the final day of the conference that I was kicked out, but we should have had access to the conference materials for 60 days after it ended. We have yet to receive a response from WPATH.

I did have an opportunity to ask this question in person at the Annual Transgender Health Summit in San Francisco a few months later. I directed the question to four representatives from the American Psychological Association (APA), who are writing the APA’s Guidelines for Working with Transgender and Gender Diverse Patients. The response was much more civil in person than online, but they still didn't have an answer. One of them told me it is not a Psychologist’s job to decide who is trans and who isn’t trans. They are training the Psychologists to affirm what their patient tells them their gender is, and to assist them in obtaining medical intervention to

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"achieve their embodiment goals." Another one dodged the question but in a scolding tone told me that implying anyone could be harmed by gender medicine is rooted in "fear of transness", which is simply "transphobia". The third panelist answered that it is pointless "to try to tell a teenager who they are" or to try to "make them be cis", effectively pretending I asked a question I did not ask. All of them were transgender or non-binary.

The reason I tell these stories from these trans health conferences is to demonstrate the fact that pediatric gender medicine comes with no diagnosis, no assessment, no guardrails or safe-keeping. The doctors writing these guidelines eschew any "pathologizing transness" and mandate that any minor presenting in gender clinics be immediately affirmed and assisted with accessing puberty blockers, hormones, and surgeries. Anyone, including trans people ourselves, are dismissed as 'anti-trans', 'TERFs', and 'transphobes' for even suggesting this may be unsafe or unethical.

The LGBT Courage Coalition was founded by Jamie [redacted], a whistleblower from a pediatric gender clinic that was doing this kind of 'gender-affirming care'. Jamie is being called a liar by her critics for saying her clinic was doing exactly what these activists advocated for and have now codified into medical guidelines. Every clinic who follows WPATH and the APA's guidelines for working with transgender youth will operate in the same manner as Jamie's clinic, because that is what they have been instructed to do. The reason these same trans activist clinicians accuse Jamie of lying and GDA of being anti-trans is because they have to believe no harm could possibly come from affirmation only gender healthcare, because if it did, they would be responsible for it.

The longer they censor and defame anyone sounding alarms, the more young people are harmed, and the more culpable they become.

A guest post by

Aaron Terrell

I write about gender and sexuality

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July 18, 2023

The Honorable Charles Schumer
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Hakeem Jeffries
House Minority Leader
U.S. House of Representatives
Washington, DC 20515

The Honorable Patty Murray
Chairwoman
Senate Appropriations Committee
Washington, DC 20510

The Honorable Rosa DeLauro
Ranking Member
House Appropriations Committee
Washington, DC 20510

Dear Members of Congress,

We, the 63 undersigned organizations dedicated to advancing the science of medicine, providing quality health care, and improving the health and well-being of people, families, and communities across the country, call on Congress to reject efforts to ban access to medically necessary gender-affirming care for transgender people.

Health care to treat gender dysphoria is medically necessary, evidence-based care provided to transgender people to alleviate the psychological distress associated with incongruence between an individual's gender and their sex assigned at birth. Gender dysphoria is recognized as a serious medical condition by every major U.S. medical association and the World Health Organization. This health care encompasses mental health counseling, social affirmation (e.g., using a person's chosen name and pronouns), and medical services such as hormone therapy that allow transgender people to live safely and authentically as who they are. Every major medical and mental health association in the U.S., representing more than 1.3 million U.S. doctors,[i] supports individualized, age-appropriate gender-affirming care that promotes the health and well-being of transgender people.

A robust body of evidence compiled over the last 50 years has demonstrated that gender-affirming care is safe, effective care that improves the physical health and mental health of transgender people. For example, research has shown that receipt of gender-affirming care among young people (aged 13 to 20) was associated with 60% lower odds of depression and 73% lower odds of suicidality.[ii] Other studies have found similar positive impacts[iii] on the mental health of transgender and nonbinary youth, including a nearly 40% lower odds of having a suicide attempt in the past year when they have access to gender-affirming hormone therapy.[iv] For transgender adults, gender-affirming surgeries are associated with reduced rates of suicide attempts, anxiety, depression, and symptoms of gender dysphoria, along with higher levels of life satisfaction, happiness, and quality of life.[v]

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In the U.S., individualized, age-appropriate care is provided to transgender people by licensed medical professionals according to expert standards of clinical care that have been in place for decades, such as those maintained by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society.[vi] The WPATH Standards, which are in their eighth edition as of September 2022, are based on dozens of independent systematic reviews and a consensus-based expert review process involving more than 100 experts from around the world. These standards ensure that decision-making about health care for transgender people is guided by a multi-disciplinary care team of medical and mental health professionals working together with patients and, for minors, with their parents, to assess and meet the patient's medical needs. This enables health professionals to help transgender patients navigate safe and effective pathways to care that maximizes their physical and psychological well-being. We stand firmly behind the robust evidence base and expert clinical guidelines that demonstrate this care is safe, effective, and medically necessary for transgender people to thrive.

Recently we have seen a surge of state and federal efforts to eliminate access to medically necessary care for transgender people. Currently, twenty states have enacted legislation banning care for adolescents; five of these bans enact felony penalties against health care professionals for following their professional oath to provide ethical, evidence-based care.[vii] Increasingly, state officials are also seeking to restrict access to this care for transgender adults.[viii] These efforts have now made their way to Congress, where federal lawmakers are attempting to ban gender-affirming care through legislative attacks that take many forms[ix]—standalone bills, harmful amendments to legislation on an array of unrelated topics, or threats to withhold funding from essential programs and services.

We strongly oppose these discriminatory state and federal efforts to ban best-practice, evidence-based care for transgender people. These efforts contradict long-standing expert clinical standards and represent governmental intrusion into the practice of medicine, as well as the privacy and sanctity of the relationship between medical professionals, patients, and parents. We call on Congress to reject these harmful proposals and urge it to leverage its power to protect access to medically necessary gender-affirming care for transgender people across the country.

Thank you for your consideration. If you need any more information, please do not hesitate to contact Kellan Baker, Executive Director and Chief Learning Officer for Whitman-Walker Institute at KBaker@Whitman-Walker.org or Caroline Medina, Director of Policy for Whitman-Walker Institute at CMedina@Whitman-Walker.org.

Respectfully,

ABIM Foundation
American Academy of Physician Associates
American Board of Internal Medicine

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American College of Physicians
American Medical Student Association (AMSA)
American Psychiatric Association
American Psychological Association
Anchor Health
Apicha Community Health Center
Be BOLD Psychology and Consulting
Boston Medical Center
Bright Tree Therapy, PLLC
Callen-Lorde Community Health Center
Charlotte Trans Health
CHMG Pediatric Specialists
Clear Sky Therapeutic Services, PLLC
Community Love Direct Primary Care, PLLC
Create the Pause Therapy
Create Your Calm PLLC
CrescentCare
The Eidos LGBTQ+ Health Initiative at the University of Pennsylvania
El Rio Community Health Center
Empowered Transitions
Endocrine Society
The Fenway Institute
FOLX Health
Gaia Therapy LLC
Gender Specialist, LLC
Gender Wellness Center, Bassett Healthcare Network
GLMA: Health Professionals Advancing LGBTQ+ Equality
Healing Arts Collaborative
Healing Path Counseling and Wellness PLLC
Horizon Counseling Center
Howard Brown Health
Inner Guidance Counseling PLLC
Intersections, LLC
Julia Springer Therapy

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Basil Guyer Therapy
Lyon-Martin Community Health Services
Metamorphosis Medical Center
Mosaic Health and Healing Arts
National Association of Social Workers
North Carolina Psychological Association
NorthLakes Community Clinic
Nourish Adolescent Wellness
Physicians for Reproductive Health
Radical Well-Being Center
Reaching Resolution, LLC
Return to Center Psychotherapy, PLLC
Rooted Therapy
Second Breakfast Nutrition
Shital Patel PLLC
St. Louis Behavioral Medicine Institute
TKC Psychotherapy, PLLC
Transhealth
US Professional Association for Transgender Health (USPATH)
Vada Counseling
Western North Carolina Community Health Services
Whitman-Walker Institute
Whole Being Therapy
Wiconi Counseling Center Utah
Wild Spring Counseling
World Professional Association for Transgender Health (WPATH)

Cc: The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
Washington, DC 20510

The Honorable Bernard Sanders
Chair
Senate Committee on Health, Education, Labor and Pensions
Washington, DC 20510

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[i] The Human Rights Campaign, "Get the Facts on Gender-Affirming Care," available at https://www.hrc.org/resources/get-the-facts-on-gender-affirming-care (last accessed July 7, 2023)

[ii] Tordoff, D. M., Wanta, J. W., Collin, A., Stepney, C. S., Inwards-Breland, D. J., & Ahrens, K. (2022). Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Network Open, 5*(2). doi:10.1001/jamanetworkopen.2022.0978

[iii] Ramos, G. G. F., Mengai, A. C. S., Daltro, C. A. T., Cutrim, P. T., Zlotnik, E., & Beck, A. P. A. (2021). Systematic Review: Puberty suppression with GnRH analogues in adolescents with gender incongruity. *Journal of Endocrinological Investigation, 44*(6):1151-1158. doi: 10.1007/s40618-020-01449-5

[iv] Green, A. E., DeChants, J. P., Price, M. N., & Davis, C. K. (2021). Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. *Journal of Adolescent Health, 70*(4). 643 – 649. https://doi.org/10.1016/j.jadohealth.2021.10.036

[v] Swan, J., Phillips, T. M., Sanders, T., Mullens, A. B., Debattista, J. & Bromdal, A. (2022). Mental health and quality of life outcomes of gender-affirming surgery: A systematic literature review. *Journal of Gay & Lesbian Mental Health.* DOI: 10.1080/19359705.2021.2016537; 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*(1), 1-5.

[vi] Coleman, E., Radix, A. E., Bouman, W.P., Brown, G.R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F.L., Monstrey, S. J., Motmans, J., Nahata, L., ... Arcelus, J. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health*, *23*(S1), S1-S260. https://doi.org/10.1080/26895269.2022.2100644 ; Wylie C Hembree and others, Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *The Journal of Clinical Endocrinology & Metabolism*, Volume 102, Issue 11, 1 November 2017, Pages 3869–3903, https://doi.org/10.1210/jc.2017-01658

[vii] Movement Advancement Project. April 2023. *LGBTQ Policy Spotlight: Bans on Medical Care for Transgender People.* https://www.mapresearch.org/2023-medical-care-bans-report

[viii] Ibid.

[ix] See, for example: H.R. 3328 – 118th Congress (2023-2024): Protecting Children from Experimentation Act, available at https://www.congress.gov/bill/118th-congress/house-bill/3328?q=%7B%22search%22%3A%5B%22Protecting+Children+from+Experimentation+Act%22%5D%7D&s=1&r=2; H.R. 3887 – 118th Congress (2023-2024): Children's Hospital Reauthorization Act of 2023, available at https://www.congress.gov/bill/118th-congress/house-bill/3887; Sec. 8143 of the Full Committee Markup of Fiscal Year 2024 Defense and Energy and Water Development and Related Agencies Bills, available at https://appropriations.house.gov/legislation/markups/markup-fiscal-year-2024-defense-and-energy-and-water-development-and-related

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@questfamilies.com>
Sent: Thursday, July 20, 2023 5:47 PM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: CE inquiry for USF therapists?

This Message Is From an External Sender
This message came from outside your organization.

Thanks Maddie,

I am well! I hope you are too and not too overwhelmed with all your roles. BTW: you can always refer folks like this to us atttps://www.genderhealthtraining.com. I will follow up with her.

Warmly,
[redacted]

[redacted]
Pronouns: He, Him, Him ([redacted])
Licensed Psychologist, [redacted]

WPATH Certified Gender Specialist
WPATH Certified Mentor

[redacted] *The Gender Health Training Institute | The TransFamily Alliance*
www.questfamilies.com | www.genderhealthtraining.com | www.transfamilyalliance.com
Email: [redacted]@questfamilies.com | [redacted]@genderhealthtraining.com
PH: [redacted]

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On Jul 20, 2023, at 4:40 PM, Deutsch, Madeline <Madeline.Deutsch@ucsf.edu> wrote:

Hi! Hope all is well. Does this interest you? If so, please feel free to contact them directly.

Cheers,

Maddie

From: [redacted]@usfca.edu>
Sent: Tuesday, July 18, 2023 3:22 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: CE inquiry for USF therapists?

Greetings, Dr. Deutsch,

I coordinate the CE program at University of San Francisco's student counseling center. I'm wondering if a medical provider from your clinic would be willing to provide a 1 or 2 hour CE presentation to our staff via Zoom at some point this fall? I'm not sure if this is a service you offer or not, but I figured I would ask!

Thank you,

[redacted]

Crisis Manager/Licensed Staff Psychologist
Counseling and Psychological Services
University of San Francisco

415-422-6351

https://urldefense.com/v3/__https[redacted]

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Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, July 20, 2023 6:26 PM PDT
To: [redacted]@questfamilies.com>
Subject: Re: CE inquiry for USF therapists?

Thanks [redacted]!

From: [redacted]@questfamilies.com>
Sent: Thursday, July 20, 2023 5:47 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: CE inquiry for USF therapists?

This Message Is From an External Sender
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Thanks Maddie,

I am well! I hope you are too and not too overwhelmed with all your roles. BTW: you can always refer folks like this to us https://www.genderhealthtraining.com. I will follow up with her.

Warmly,
[redacted]

[redacted]
Pronouns: He, His, Him ([redacted])
Licensed Psychologist [redacted]

WPATH Certified Gender Specialist
WPATH Certified Mentor

[redacted] *The Gender Health Training Institute | The TransFamily Alliance*
www.questfamilies.com | www.genderhealthtraining.com | www.transfamilyalliance.com
Email: [redacted]@questfamilies.com [redacted]@genderhealthtraining.com
Ph: [redacted]

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Cheers,

Maddie

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Thank you,

[redacted]

Crisis Manager/Licensed Staff Psychologist
Counseling and Psychological Services
University of San Francisco

415-422-6351

https://urldefense.com/v3/__https://myusf.usfca.edu[redacted]

Please be aware that I do not maintain 24-hour access to e-mail- please DO NOT use email for emergencies. For urgent mental health concerns/crises, go to the nearest emergency room, call 911 or local emergency services, call CAPS All Hours 24/7 (855-531-0761), or USF Public Safety 24/7 (415-422-2911). Please also note that e-mail does not ensure confidentiality. This correspondence and attachments are intended for the person(s) named above and may contain confidential information. If you have received this message in error, please notify me by return e-mail and delete the correspondence and attachments.

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@NorthMemorial.com>
Sent: Friday, July 21, 2023 7:31 AM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: GnRh agonists - Lupron dosing

This Message Is From an External Sender
This message came from outside your organization.

Good morning Dr. Deutsch,

I am the Gender Care Manager at North Memorial Health in Minnesota. I am reaching out to see if you can provide any guidance around leuprolide acetate dosing for puberty suppression.

Historically we have been using Zoladex, however we have had to recently switch to Lupron for a few of our patients due to insurance issues. I have been trying to find guidelines around dosing for our providers but have been coming up short, especially for older adolescents. I appreciate any advice you could offer.

Best regards,

[redacted]MSN, RN, PHN
He/him/his
Care Management Program
Gender Care
Direct: [redacted]
[redacted]@NorthMemorial.com
NorthMemorial.com

NORTH
MEMORIAL HEALTH
CLINIC

Obtained via CPRA by Judicial Watch, Inc.

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From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Friday, July 21, 2023 11:11 AM PDT
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Fw: GnRh agonists - Lupron dosing

Any input?

From: [redacted]@NorthMemorial.com>
Sent: Friday, July 21, 2023 7:31 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: GnRh agonists - Lupron dosing

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Best regards,

[redacted]
He/him/his
Care Management Program
Gender Care
[redacted]
NorthMemorial.com

NORTH
MEMORIAL HEALTH
CLINIC

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Friday, July 21, 2023 11:13 AM PDT
To: [redacted]@NorthMemorial.com>
Subject: Re: GnRh agonists - Lupron dosing

Hi [redacted]

I've forwarded this on to a colleague who may be better positioned to respond.

Maddie

From: [redacted]@NorthMemorial.com>
Sent: Friday, July 21, 2023 7:31 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: GnRh agonists - Lupron dosing

This Message Is From an External Sender
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Best regards,

[redacted]
He/him/his
Care Management Program
Gender Care
[redacted]
NorthMemorial.com

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MEMORIAL HEALTH
CLINIC

Obtained via CPRA by Judicial Watch, Inc.

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, July 24, 2023 9:24 PM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: GnRh agonists - Lupron dosing

We typical use 30 mg q 3 month Lupron. There is a newer 45 mg q 6 month Lupron. Triptodur (just one dose formulation is available—I believe it's 22 mg) q 6 months is another option.
Steve

Get Outlook for iOS

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Friday, July 21, 2023 11:11:51 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Fw: GnRh agonists - Lupron dosing

Any input?

From: [redacted]@NorthMemorial.com>
Sent: Friday, July 21, 2023 7:31 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: GnRh agonists - Lupron dosing

This Message Is From an External Sender
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Best regards,

[redacted]
He/him/his
Care Management Program
Gender Care
[redacted]@NorthMemorial.com
NorthMemorial.com

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Obtained via CPRA by Judicial Watch, Inc.

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, July 24, 2023 9:25 PM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: GnRh agonists - Lupron dosing

Triptodur is 22.5 mg.

Get Outlook for iOS

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Monday, July 24, 2023 9:24:25 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: GnRh agonists - Lupron dosing

We typical use 30 mg q 3 month Lupron. There is a newer 45 mg q 6 month Lupron. Triptodur (just one dose formulation is available—I believe it's 22 mg) q 6 months is another option.
Steve

Get Outlook for iOS

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Friday, July 21, 2023 11:11:51 AM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: Fw: GnRh agonists - Lupron dosing

Any input?

From: [redacted]@NorthMemorial.com>
Sent: Friday, July 21, 2023 7:31 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: GnRh agonists - Lupron dosing

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Best regards,

[redacted]
He/him/his
Care Management Program
Gender Care
[redacted]
NorthMemorial.com

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Obtained via CPRA by Judicial Watch, Inc.

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From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, July 25, 2023 12:38 PM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Sperm

Hi Maddie,

I've referred patients to Sperm Bank of CA, but that's the extent of my experience.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Tuesday, July 25, 2023 12:36 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Fw: Sperm

Hi - please see below. Have you had patients use this sperm storage service? Do you have others you use? I've used Cal Cryo and Sperm Bank of CA, My understanding is that Cal Cryo is no longer doing home collection and storage.

Cheers,

Maddie

From: [redacted]@gmail.com>
Sent: Sunday, July 23, 2023 10:56 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Sperm

This Message Is From an Untrusted Sender
You have not previously corresponded with this sender.

https://www.givelegacy.com/solutions/trans-fertility?_gl=1%2A4xklcw%2A_ga%2AMTY1NTEzNjc1OS4xNjkwMTM0ODI4%2A_ga_RP6EDKZ598%2AMTY5MDEzNDgyNy4xLjAuMTY5MDEzNDgyNy42MC4wLjA.

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, July 27, 2023 12:09 PM PDT
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
CC: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hello, following up. Has there been any update on this? [redacted] starts in September with us.

Thanks,

Maddie

From: [redacted]@ucsf.edu>
Sent: Monday, May 8, 2023 12:57 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

Hi all,

The DEP Governance meeting invite for tomorrow just came in. I will forward to [redacted]now and will plan to attend. This request is on their agenda. Thanks.

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted], Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
Pediatric Developmental Medicine
UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
Clinic: 415-353-2080 Fax: 415-502-0014

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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, May 4, 2023 3:41 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Thanks everyone. I know Al is out this week, I'll connect with him on this next week.

Best,

Maddie

From: [redacted]@ucsf.edu>
Sent: Wednesday, May 3, 2023 8:02 PM
To: [redacted]@ucsf.edu>; Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

HI [redacted]

Here is the DEPT Request form and ticket submitted to start the process. when you return pls review the form (yellow sections) to complete as we will need to resubmit/present at the next Apex Governance Committee meeting.
Ticket/request will be reviewed by Apex team, then we (you and I) will be invited to the Apex Governance meeting to finalize. Then they will create the new dep.

Thank you,
[redacted]

Ticket #: INC8944140
Description: Requesting a new DEP at 1725 Montgomery Street location.

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted] Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
Pediatric Developmental Medicine
UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
Clinic: 415-353-2080 Fax: 415-502-0014

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From: [redacted]@ucsf.edu>
Sent: Thursday, April 27, 2023 3:58 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

My Chart Messages can be routed to Pool 2100062 UCSF AMB TRANSGENDER CLINICAL STAFF

[redacted], RN
Nurse Manager
360 Positive Care Clinic /Womens Specialty Health/Transgender Care
UCSF Medical Center
350 Parnassus Avenue Suite 908
San Francisco, California 94143
Cell: [redacted]
Tel: 415-353-2503
Fax: 415-353-2406
Pronouns: He, His

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, April 27, 2023 3:55 PM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]

[redacted] is our manager and is cc'ed here. [redacted]s template, schedule, inbox messages for patients seen in this clinic, referrals WQ etc will all be managed by our Montgomery Staff. What we have done for our other providers working on their own DEP is have our staff person granted access to manage their templates and WQ etc.. and the MyChart inbox items are routed to our pool.

From: [redacted]@ucsf.edu>
Sent: Thursday, April 27, 2023 2:13 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

Hi Dr. Deutsch,

Got it and makes sense to remove ped. Since the dep will be adult, can you lmk who the adult practice manager is that is managing the staff, and will sort this out with them.

If the goal is for adult endo team to manage the staff who will be responsible for the associated WQ and template, then new dep for [redacted] should match your existing Endo Montgomery DEPs (except for the cost center and funds flow specific routing)

I have completed the new dep request form and would like to review/update before it's submitted.

Thank you,
[redacted]

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Wednesday, April 26, 2023 3:31 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]

[redacted] will be seeing only adult patients in our adult clinic. It might make more sense to name the DEP without the word "ped" in it to avoid system confusion.

[redacted] will function operationally as part of our clinic. We are creating a DEP for her only to facilitate the Funds Flow arrangement. We will handle all scheduling, as well as inbox items/pools that come in for her patients seen at this location.

Please let me know if you have any further questions.

Maddie

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, April 26, 2023 3:26 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]

I have cc'd Dr. Maddie Deutsch, Director of Adult Transgender Services, who should be able to answer your question.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his
Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 11:44 AM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: FW: Ped Endo (Gender) Montgomery

Hi Drs. [redacted] Rosenthal,

Can you clarify who will be scheduling patients for [redacted] at Montgomery location?
See [redacted]'s response below in blue italic.

Once you confirm then I can proceed with submitting the request for Apex Govn team.

Thank you,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 11:04 AM
To: [redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted]
See answers below.
Thanks,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 10:08 AM
To: [redacted]@ucsf.edu>
Subject: Ped Endo (Gender) Montgomery

Hi [redacted]

Can you please review attached Dep request form (yellow areas) and confirm below:

1. Are we mimicking Ped Gender Pritzker Dep? *YES, mostly*
2. Can Apex DEP name bePED GENDER MONTGOMERY same as what we have for Pritzker? Dr. Deutsch suggested ENDO MONTGOMERY. *Yes, let's keep it standard with Ped APEX DEP nomenclature*
3. Which cost center are associating this DEP with? *707820*~~or 707050~~ Yes, *let's try to use the new Gender cost center ; we can change per APEX Governance recommendation.*
4. These info will be same as Ped Gender Pritzker: phone #, fax#, WQ ID's;*Not sure, are we the one's scheduling patients into this clinic and managing Dr [redacted]'s clinic schedule? If we are the one's registering patients for this clinic, then I think we need to review with the partnering team what makes sense for these patients just to make sure patients receive the correct info and we receive the wRVU funds in Peds.*

When I s/w Dr. [redacted] yesterday, she said [redacted] will be seeing adult gender patients. those patients that transition out from Pritzker.

Summary:
Request to create a new Apex dep for [redacted]@ucsf.edu clinic. She will have one clinic session per week starting in August or September of this year. Clinic day is TBD. Funds flow to be routed to Peds Endo, home department. Clinic location will be1725 Montgomery St, Suite 250, San Francisco, CA 94111.

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Thank you,
[redacted]

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted] Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
Pediatric Developmental Medicine
UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
Clinic: 415-353-2080 Fax: 415-502-0014

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Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@NorthMemorial.com>
Sent: Thursday, July 27, 2023 3:17 PM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Guidelines for gender affirming care-puberty blockers.

This Message Is From an External Sender
This message came from outside your organization.

Dr. Deutsch,
I am a primary care provider in MN that provides gender affirming care. I am a member of a team here that includes Dr. [redacted] RN coordinator. Dr. [redacted] and I were present at the WPATH conference in Montreal last year. It was nice to see everyone there! I was reviewing the guidelines on the UCSF website recently and noticed a lack of information about GNRH treatments. Do you have guidelines available for this type of care as well. We have been experiencing an influx of people coming to MN from surrounding states that have limited gender affirming care to trans youth. We want to be sure we are consistent with what others health systems are doing. Thank you for any information you can share!

[redacted]
North Memorial Clinic Brooklyn Center
[redacted]
[redacted]@NorthMemorial.com
northmemorial.com

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, July 27, 2023 3:18 PM PDT
To: [redacted]@NorthMemorial.com>
Subject: Re: Guidelines for gender affirming care-puberty blockers.

Hi. Thanks for your inquiry. This info will be included in the planned revision coming in 2024.

Maddie

From: [redacted]@NorthMemorial.com>
Sent: Thursday, July 27, 2023 3:17 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Guidelines for gender affirming care-puberty blockers.

This Message Is From an External Sender
This message came from outside your organization

Dr. Deutsch,
I am a primary care provider in MN that provides gender affirming care. I am a member of a team here that includes Dr. [redacted] were present at the WPATH conference in Montreal last year. It was nice to see everyone there! I was reviewing the guidelines on the UCSF website recently and noticed a lack of information about GNRH treatments. Do you have guidelines available for this type of care as well. We have been experiencing an influx of people coming to MN from surrounding states that have limited gender affirming care to trans youth. We want to be sure we are consistent with what others health systems are doing. Thank you for any information you can share!

[redacted]**PA-C (They/She)**
North Memorial Clinic Brooklyn Center
[redacted]
[redacted]
[redacted]@NorthMemorial.com
northmemorial.com

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: [redacted]@ucsf.edu>
Sent: Thursday, July 27, 2023 6:24 PM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
CC: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

Hi All,

Apologies for the delay on this. The new cost center request is awaiting [redacted] signature. He just returned from PTO yesterday. Once there's a new cost center approved, the new APEX DEP can be created to align with Ped Endo. I will be on PTO till mid-August and [redacted] can provide updates as it moves along the approval process.

Thanks,
[redacted]

[redacted], MSN, RN
Director
Pediatric Specialties Outpatient Services
Benioff Children's Hospital San Francisco
UCSF Health
Office: 415-476-4290
Pronouns: she, her, hers

UCSF Benioff Children's Hospitals

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---

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, July 27, 2023 12:10 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hello, following up. Has there been any update on this? [redacted] starts in September with us.

Thanks,

Maddie

From: [redacted]@ucsf.edu>
Sent: Monday, May 8, 2023 12:57 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

Hi all,

The DEP Governance meeting invite for tomorrow just came in. I will forward to [redacted] now and will plan to attend. This request is on their agenda. Thanks.

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted] Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
Pediatric Developmental Medicine
UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
Clinic: 415-353-2080 Fax: 415-502-0014

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Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, May 4, 2023 3:41 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Thanks everyone. I know [redacted]s out this week, I'll connect with him on this next week.

Best,

Maddie

From: [redacted]@ucsf.edu>
Sent: Wednesday, May 3, 2023 8:02 PM
To: [redacted]@ucsf.edu>; Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

HI [redacted],

Here is the DEPT Request form and ticket submitted to start the process. when you return pls review the form (yellow sections) to complete as we will need to resubmit/present at the next Apex Governance Committee meeting.
Ticket/request will be reviewed by Apex team, then we (you and I) will be invited to the Apex Governance meeting to finalize. Then they will create the new dep.

Thank you,
[redacted]

Ticket #: INC8944140
Description: Requesting a new DEP at 1725 Montgomery Street location.

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted], Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
Pediatric Developmental Medicine
UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
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From: [redacted]@ucsf.edu>
Sent: Thursday, April 27, 2023 3:58 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

My Chart Messages can be routed to Pool 2100062 UCSF AMB TRANSGENDER CLINICAL STAFF

[redacted], RN
Nurse Manager
360 Positive Care Clinic /Womens Specialty Health/Transgender Care
UCSF Medical Center
350 Parnassus Avenue Suite 908
San Francisco, California 94143
Cell: [redacted]
Tel: 415-353-2503
Fax: 415-353-2406
Pronouns: He, His

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, April 27, 2023 3:55 PM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted],

[redacted] is our manager and is cc'ed here. [redacted]s template, schedule, inbox messages for patients seen in this clinic, referrals WQ etc will all be managed by our Montgomery Staff. What we have done for our other providers working on their own DEP is have our staff person granted access to manage their templates and WQ etc.. and the MyChart inbox items are routed to our pool.

From: [redacted]@ucsf.edu>
Sent: Thursday, April 27, 2023 2:13 PM

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

Hi Dr. Deutsch,

Got it and makes sense to remove ped. Since the dep will be adult, can you lmk who the adult practice manager is that is managing the staff, and will sort this out with them.

If the goal is for adult endo team to manage the staff who will be responsible for the associated WQ and template, then new dep for [redacted] should match your existing Endo Montgomery DEPs (except for the cost center and funds flow specific routing)

I have completed the new dep request form and would like to review/update before it's submitted.

Thank you,
[redacted]

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Wednesday, April 26, 2023 3:31 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted],

[redacted] will be seeing only adult patients in our adult clinic. It might make more sense to name the DEP without the word "ped" in it to avoid system confusion.

[redacted] will function operationally as part of our clinic. We are creating a DEP for her only to facilitate the Funds Flow arrangement. We will handle all scheduling, as well as inbox items/pools that come in for her patients seen at this location.

Please let me know if you have any further questions.

Maddie

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, April 26, 2023 3:26 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted],

I have cc'd Dr. Maddie Deutsch, Director of Adult Transgender Services, who should be able to answer your question.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his
Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 11:44 AM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: FW: Ped Endo (Gender) Montgomery

Hi Drs. [redacted] Rosenthal,

Can you clarify who will be scheduling patients for [redacted] at Montgomery location?
See [redacted]'s response below in blue italic.

Once you confirm then I can proceed with submitting the request for Apex Govn team.

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

Thank you,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 11:04 AM
To: [redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted],
See answers below.
Thanks,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 10:08 AM
To: [redacted]@ucsf.edu>
Subject: Ped Endo (Gender) Montgomery

Hi [redacted]

Can you please review attached Dep request form (yellow areas) and confirm below:

1. Are we mimicking Ped Gender Pritzker Dep? *YES, mostly*
2. Can Apex DEP name be PED GENDER MONTGOMERY same as what we have for Pritzker? Dr. Deutsch suggested ENDO MONTGOMERY. *Yes, let's keep it standard with Ped APEX DEP nomenclature*
3. Which cost center are associating this DEP with? *707820* ~~or 707050~~ Yes, *let's try to use the new Gender cost center ; we can change per APEX Governance recommendation.*
4. These info will be same as Ped Gender Pritzker: phone #, fax#, WQ ID's; *Not sure, are we the one's scheduling patients into this clinic and managing Dr.* [redacted]*'s clinic schedule? If we are the one's registering patients for this clinic, then I think we need to review with the partnering team what makes sense for these patients just to make sure patients receive the correct info and we receive the wRVU funds in Peds.*

When I s/w Dr. [redacted] yesterday, she said [redacted] will be seeing adult gender patients. those patients that transition out from Pritzker.

Summary:
Request to create a new Apex dep for [redacted]@ucsf.edu clinic. She will have one clinic session per week starting in August or September of this year. Clinic day is TBD. Funds flow to be routed to Peds Endo, home department. Clinic location will be 1725 Montgomery St, Suite 250, San Francisco, CA 94111.

Thank you,
[redacted]

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted], Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
Pediatric Developmental Medicine
UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
Clinic: 415-353-2080 Fax: 415-502-0014

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From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, July 31, 2023 11:40 AM PDT
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
CC: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Thanks.

Maddie

From: [redacted] <[redacted]@ucsf.edu>
Sent: Thursday, July 27, 2023 6:24 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

Hi All,

Apologies for the delay on this. The new cost center request is awaiting [redacted] signature. He just returned from PTO yesterday. Once there's a new cost center approved, the new APEX DEP can be created to align with Ped Endo. I will be on PTO till mid-August and [redacted] can provide updates as it moves along the approval process.

Thanks,
[redacted]

[redacted], MSN, RN
Director
Pediatric Specialties Outpatient Services
Benioff Children's Hospital San Francisco
UCSF Health
Office: 415-476-4290
Pronouns: she, her, hers

UCSF Benioff Children's Hospitals

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---

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, July 27, 2023 12:10 PM
To: [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hello, following up. Has there been any update on this? [redacted] starts in September with us.

Thanks,

Maddie

From: [redacted]@ucsf.edu>
Sent: Monday, May 8, 2023 12:57 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

Hi all,

The DEP Governance meeting invite for tomorrow just came in. I will forward to [redacted] now and will plan to attend. This request is on their agenda. Thanks.

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted] Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
Pediatric Developmental Medicine
UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
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From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, May 4, 2023 3:41 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]>
Subject: Re: Ped Endo (Gender) Montgomery

Thanks everyone. I know [redacted]s out this week, I'll connect with him on this next week.

Best,

Maddie

From: [redacted]@ucsf.edu>
Sent: Wednesday, May 3, 2023 8:02 PM
To: [redacted]@ucsf.edu>; Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

HI [redacted]

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Ticket/request will be reviewed by Apex team, then we (you and I) will be invited to the Apex Governance meeting to finalize. Then they will create the new dep.

Thank you,
[redacted]

Ticket #: INC8944140
Description: Requesting a new DEP at 1725 Montgomery Street location.

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted] Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
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UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
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From: [redacted]@ucsf.edu>
Sent: Thursday, April 27, 2023 3:58 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

My Chart Messages can be routed to Pool 2100062 UCSF AMB TRANSGENDER CLINICAL STAFF

[redacted] RN
Nurse Manager
360 Positive Care Clinic /Womens Specialty Health/Transgender Care
UCSF Medical Center
350 Parnassus Avenue Suite 908
San Francisco, California 94143
Cell: [redacted]
Tel: 415-353-2503
Fax: 415-353-2406
Pronouns: He, His

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Thursday, April 27, 2023 3:55 PM
To: [redacted]@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted],

[redacted] is our manager and is cc'ed here. [redacted]s template, schedule, inbox messages for patients seen in this clinic, referrals WQ etc will all be managed by our Montgomery Staff. What we have done for our other providers working on their own DEP is have our staff person granted access to manage their templates and WQ etc.. and the MyChart inbox items are routed to our pool.

From: [redacted]@ucsf.edu>
Sent: Thursday, April 27, 2023 2:13 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Cc: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>
Subject: RE: Ped Endo (Gender) Montgomery

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Thank you,
[redacted]

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Wednesday, April 26, 2023 3:31 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted]@ucsf.edu>; [redacted]
<[redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

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Please let me know if you have any further questions.

Maddie

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Wednesday, April 26, 2023 3:26 PM
To: [redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Cc: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted],

I have cc'd Dr. Maddie Deutsch, Director of Adult Transgender Services, who should be able to answer your question.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences

550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his
Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356

Obtained via CPRA by Judicial Watch, Inc.

Obtained via CPRA by Judicial Watch, Inc.

email: Stephen.Rosenthal@ucsf.edu

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 11:44 AM
To: [redacted]@ucsf.edu>; Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Subject: FW: Ped Endo (Gender) Montgomery

Hi Drs. [redacted] Rosenthal,

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See [redacted]'s response below in blue italic.

Once you confirm then I can proceed with submitting the request for Apex Govn team.

Thank you,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 11:04 AM
To: [redacted]@ucsf.edu>
Subject: Re: Ped Endo (Gender) Montgomery

Hi [redacted],
See answers below.
Thanks,
[redacted]

From: [redacted]@ucsf.edu>
Sent: Wednesday, April 26, 2023 10:08 AM
To: [redacted]@ucsf.edu>
Subject: Ped Endo (Gender) Montgomery

Hi [redacted]

Can you please review attached Dep request form (yellow areas) and confirm below:

1. Are we mimicking Ped Gender Pritzker Dep? *YES, mostly*
2. Can Apex DEP name be PED GENDER MONTGOMERY same as what we have for Pritzker? Dr. Deutsch suggested ENDO MONTGOMERY. *Yes, let's keep it standard with Ped APEX DEP nomenclature*
3. Which cost center are associating this DEP with? *707820* ~~or 707050~~ Yes, *let's try to use the new Gender cost center ; we can change per APEX Governance recommendation.*
4. These info will be same as Ped Gender Pritzker: phone #, fax#, WQ ID's; *Not sure, are we the one's scheduling patients into this clinic and managing Dr. [redacted]'s clinic schedule? If we are the one's registering patients for this clinic, then I think we need to review with the partnering team what makes sense for these patients just to make sure patients receive the correct info and we receive the wRVU funds in Peds.*

When I s/w Dr. [redacted] yesterday, she said [redacted] will be seeing adult gender patients. those patients that transition out from Pritzker.

Summary:
Request to create a new Apex dep for [redacted]@ucsf.edu clinic. She will have one clinic session per week starting in August or September of this year. Clinic day is TBD. Funds flow to be routed to Peds Endo, home department. Clinic location will be1725 Montgomery St, Suite 250, San Francisco, CA 94111.

Thank you,
[redacted]

[redacted]
Practice Manager
UCSF Benioff Children's Hospital
Mobile: [redacted] Desk: [redacted]
Madison Clinic for Pediatric Diabetes
UC Box 0318
1500 Owens Street, SF Ca 94143
Clinic: 415-514-6234 Fax: 415-353-2811
Pediatric Developmental Medicine
UC Box 3132
675 18th Street, 2nd floor, SF Ca 94143
Clinic: 415-353-2080 Fax: 415-502-0014

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From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, July 31, 2023 1:33 PM PDT
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Sperm

Thanks Steve!

From: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>
Sent: Tuesday, July 25, 2023 12:38 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Re: Sperm

Hi Maddie,

I've referred patients to Sperm Bank of CA, but that's the extent of my experience.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
550 16th St., 4th Floor, #4635
San Francisco CA 94143-0434
Pronouns: he/him/his

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society

Tel.: (415) 476-2266
Fax: (415) 476-5356
email: Stephen.Rosenthal@ucsf.edu

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Tuesday, July 25, 2023 12:36 PM
To: Rosenthal, Stephen <Stephen.Rosenthal@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Subject: Fw: Sperm

Hi - please see below. Have you had patients use this sperm storage service? Do you have others you use? I've used Cal Cryo and Sperm Bank of CA, My understanding is that Cal Cryo is no longer doing home collection and storage.

Cheers,

Maddie

From: [redacted]@gmail.com>
Sent: Sunday, July 23, 2023 10:56 AM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Sperm

This Message Is From an Untrusted Sender
You have not previously corresponded with this sender.

https://www.givelegacy.com/solutions/trans-fertility?_gl=1%2A4xklcw%2A_ga%2AMTY1NTEzNjc1OS4xNjkwMTM0ODI4%2A_ga_RP6EDKZ598%2AMTY5MDEzNDgyNy4xLjAuMTY5MDEzNDgyNy42MC4wLjA.

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From: Deutsch, Madeline on behalf of Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, July 31, 2023 2:06 PM PDT
To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Revised surgery letter template

Great. I've updated the website, and have operationalized this into a smart phrase. Adding [redacted] and [redacted]. This is the new format for WPATH "Letters". I've shared the smart phrase with [redacted] and Sen, you can then copy from mine and modify for your credentials etc....

.GAHPSURGERYLETTERDEUTSCH

From: [redacted]@ucsf.edu>
Sent: Sunday, July 23, 2023 8:33 PM
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Revised surgery letter template

Hi Maddie,
I think this looks great! Thanks for editing.

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Friday, July 21, 2023 12:17 AM
To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Revised surgery letter template

Hi [redacted], I am sorry for the delayed reply. Please see attached revised surgery letter template. I made some edits to simplify based on feedback we've received from outside providers about the complexity of templates we ask them to use. If you agree with this template, I can put it on the website and will also operationalize it into a template in ApEX for our internal providers to use. Let me know if you have any edits. Thanks!

Maddie

****
Maddie Deutsch, MD, MPH
Professor of Clinical Family & Community Medicine
Medical Director, UCSF Gender Affirming Health Program
UCSF Health Physician Co-Lead for Diversity, Equity, Inclusion, and Belonging
Co-Director, Differences Matter, UCSF School of Medicine
University of California - San Francisco

President, US Professional Association for Transgender Health

1725 Montgomery St, Suite 250
San Francisco, CA 94111
415-797-7136 phone
415-353-3399 fax
Madeline.Deutsch@ucsf.edu
transcare.ucsf.edu
profiles.ucsf.edu/madeline.deutsch

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From: [redacted] <[redacted]@ucsf.edu>
Sent: Monday, July 31, 2023 3:05 PM PDT
To: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>; [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Revised surgery letter template

Thank you!

From: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Sent: Monday, July 31, 2023 2:06:26 PM
To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted]@ucsf.edu>
Subject: Re: Revised surgery letter template

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Subject: Re: Revised surgery letter template

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To: [redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>; [redacted] <[redacted]@ucsf.edu>
Cc: Deutsch, Madeline <Madeline.Deutsch@ucsf.edu>
Subject: Revised surgery letter template

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