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SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF SAN FRANCISCO

EVAN MINTON, Plaintiff, v. DIGNITY HEALTH; DIGNITY HEALTH d/b/a MERCY SAN JUAN MEDICAL CENTER, Defendant.	Case No. CGC 17-558259 **PLAINTIFF EVAN MINTON'S MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO DEFENDANT DIGNITY HEALTH'S DEMURRERS TO VERIFIED COMPLAINT** Hearing Date: August 15, 2017 Hearing Time: 9:30 a.m. Dept.: 302

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INTRODUCTION

Plaintiff Evan Minton brings suit against Defendant Dignity Health for refusing to provide him medical care because of his gender identity. Dignity Health, doing business as Mercy San Juan Medical Center ("MSJMC"), refused to allow Mr. Minton, a transgender man, to undergo a hysterectomy, a medical service that it routinely provides to cisgender (*i.e.*, non-transgender) women.

Mr. Minton is transgender. Dkt. No. 1 ("Compl.") ¶ 9. His gender identity – the gender he knows himself to be – is male, though he was assigned the sex of female at birth. Compl. ¶¶ 9, 11. Like many transgender people, Mr. Minton has been diagnosed with gender dysphoria, meaning distress caused by the incongruence between his gender identity and the sex he was assigned at birth. *Id.* ¶¶ 12, 17. Mr. Minton worked with medical professionals to develop an individualized plan for treating his gender dysphoria. *Id.* ¶ 18. Mr. Minton sought to undergo a hysterectomy as part of his treatment plan, *id.,* consistent with the authoritative Standards of Care for treating gender dysphoria published by the World Professional Association for Transgender Health ("WPATH"). *See Id.* ¶¶ 13, 14; Request for Judicial Notice ("RJN") Ex. 1, at 57. Mr. Minton's physician, Dr. Lindsey Dawson, was entirely willing to perform the surgery as medically necessary care for her patient. Compl. ¶¶ 18, 19. Dr. Dawson routinely performs hysterectomies at MSJMC for cisgender female patients to address a variety of medical indications. *Id.* ¶¶ 20, 26.

Mr. Minton had scheduled a hysterectomy at MSJMC for August 30, 2016. *Id.* ¶ 19. On August 28, Mr. Minton mentioned his transgender male identity to an MSJMC nurse. *Id.* ¶ 21. The next day, Dignity Health canceled his procedure. *Id.* ¶ 22. MSJMC's president even asserted that the hospital would never allow Mr. Minton's hysterectomy to proceed. *Id.* This refusal constituted intentional, illegal discrimination that Dignity Health cannot excuse or justify by citing subsequent events or religious doctrine.

In its demurrers, Dignity Health mischaracterizes various aspects of Mr. Minton's complaint. First, Mr. Minton does not allege that Defendant discriminated against him because of a medical condition; rather, Mr. Minton alleges that Defendant discriminated against him because of sex, which the Unruh Civil Rights Act defines to include gender identity. *See Id.* ¶¶ 1, 2, 4, 5, 26, 27. Dignity

Health routinely performs hysterectomies on cisgender women, but refuses to perform them on transgender men. That disparate treatment constitutes discrimination on the basis of gender identity. Mr. Minton is not relying on a disparate impact theory, but rather has pled facts demonstrating that Defendant engaged in intentional discrimination based on his gender identity. *Id.* Further, Defendant's characterization of its actions as seamlessly connecting Mr. Minton to the care he needed outside of MSJMC misrepresents the facts, even if that hypothetical course of action would have passed muster under the Unruh Act. In reality, Mr. Minton experienced an abrupt cancellation[1] that left uncertainty about whether, when, and how he would get the health care he needed, and that caused him great anxiety and grief prior to the rescheduling and completion of his procedure at a different Dignity Health hospital several days later. *Id.* ¶¶ 22, 23.

Dignity Health also invokes religious doctrine in an unavailing attempt to justify its discriminatory treatment of Mr. Minton. Under California law, Dignity Health does not have a right to use religion to discriminate. Specifically, Defendant does not have a free exercise right to harm transgender patients, such as Mr. Minton, by prohibiting doctors from providing those patients hysterectomies or other medically necessary care, or to otherwise avoid compliance with generally applicable non-discrimination statutes like the Unruh Act. Nor does enforcing the Unruh Act in relation to MSJMC involve the Court in matters of church governance.

Mr. Minton has pled facts sufficient to state a cognizable claim of sex discrimination in violation of the Unruh Civil Rights Act. The Court should therefore deny Defendant's demurrers.

LEGAL STANDARD

Because Mr. Minton has alleged facts that are "sufficient to state a cause of action," his Complaint must survive Defendant's demurrer. *See C.A. v. William S. Hart Union High School Dist.*, 53 Cal. 4th 861, 872 (2012). In evaluating a demurrer, courts deem "all material facts pleaded in the complaint and those that arise by reasonable implication, but not conclusions of fact or law, are deemed admitted by the demurring party." *Rodas v. Spiegel*, 87 Cal. App. 4th 513, 517 (2001). "The complaint must be construed liberally by drawing reasonable inferences from the facts pleaded." *Id.* "[I]f it

[1] In fact, Defendant did not communicate with Mr. Minton about the cancellation, but rather left a message with his physician, just one day before the scheduled procedure. *See* Compl. ¶ 22.

appears that the plaintiff is entitled to any relief against the defendant, the complaint will be held good." *Cmty. Cause v. Boatwright*, 124 Cal. App. 3d 888, 896 (1981).

ARGUMENT

I. Plaintiff Has Sufficiently Pled All Elements Of His Unruh Act Sex Discrimination Claim

A. The Complaint Alleges Sex Discrimination In Violation Of The Unruh Act.

The Unruh Civil Rights Act prohibits sex discrimination in places of public accommodation, and explicitly includes "gender identity" in its definition of "sex." Cal. Civ. Code § 51(e)(5). In Sacramento County, Defendant Dignity Health does business as and through Mercy San Juan Medical Center ("MSJMC"). Compl. ¶ 10.[2] Mr. Minton and his doctor scheduled his hysterectomy to take place on August 30, 2016 at MSJMC. *Id.* ¶ 19. Then, two days before the surgery had long been scheduled to take place, Mr. Minton told MSJMC staff that he is a transgender man. *Id.* ¶ 21. In direct response to that disclosure, MSJMC cancelled his surgery. *Id.* ¶ 22. These allegations state a claim of intentional sex discrimination in violation of the Unruh Act. Contrary to Defendant's arguments, neither the events that occurred after that point, nor the specific subjective motivations for MSJMC's decision to cancel the procedure, excuse its discriminatory conduct. *See* Dkt. No. 6 ("Dem") at 8-15.

Mr. Minton does not allege that Dignity Health discriminated against him based on a medical condition; instead, Mr. Minton plainly alleges he was denied health care based on his gender identity as a transgender man. Compl. ¶¶ 1, 2, 4, 5, 26, 27. As Defendant acknowledges, Mr. Minton alleges that "[i]f Defendant is not enjoined from preventing doctors from performing hysterectomy procedures for patients with gender dysphoria in its hospitals, Mr. Minton and others similarly situated – *i.e.*, transgender individuals who suffer from gender dysphoria – will be unlawfully denied access to medical treatment at hospitals run by the largest hospital provider in California." *See* Dem. at 6; Compl. ¶ 27. Gender dysphoria exists when an individual's gender identity differs from the individual's sex assigned at birth. Compl. ¶ 12; RJN, Ex. 1, at 2. Mr. Minton suffers from gender dysphoria because he is transgender. Refusing to treat gender dysphoria is, by definition, sex discrimination against transgender

[2] MSJMC is a public accommodation subject to the Unruh Act, and Defendant does not argue otherwise. *See, e.g., Payne v. Anaheim Mem'l Med. Ctr., Inc.*, 130 Cal. App. 4th 729, 748 (2005) (holding hospital constituted public accommodation subject to the Unruh Act).

people. The medical diagnosis of gender dysphoria is relevant to Mr. Minton's claim of discrimination because it was the medical reason he needed a hysterectomy, but he is alleging sex discrimination, not medical condition discrimination.

B. Defendant's Application Of The Ethical And Religious Directives To Transgender Patients Constitutes Illegal Discrimination.

Mr. Minton does not dispute that Defendant's decision to cancel his scheduled surgery arose from its interpretation of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the U.S. Conference of Catholic Bishops ("ERDs"), which do not explicitly reference transgender people as targets of discrimination. However, Defendant's application of the ERDs constituted a denial of service to Mr. Minton because of his transgender male identity, in violation of the Unruh Act.

California courts have previously upheld Unruh Act claims challenging facially neutral policies that in fact treated protected class members differently than other individuals. For example, in *Hankins v. El Torito Restaurants,* 63 Cal. App. 4th 510, 518 (1998), the Court of Appeal upheld an Unruh Act disability discrimination claim brought by an individual who was denied access to a restaurant's first floor bathroom, and was unable to climb stairs. The restaurant argued that its policy of restricting use of the first-floor restroom to employees, and thus excluding all customers from it, was facially neutral and thus legal. The court rejected this argument, reasoning: "El Torito's policy was not, as it contends, to deny all patrons access to a restroom. Rather, a combination of its policy and the physical layout of its premises allowed patrons who were not physically handicapped to use a restroom while dining at the restaurant (the one on the second floor), but denied the same service to physically handicapped patrons even though there was a restroom on the premises (the one behind the kitchen) that a physically disabled person could otherwise use. El Torito's policy thus discriminated against disabled persons." *Id.*

In the same way, here Dignity Health has elected to apply the ERDs in a way that prohibits hysterectomies at MSJMC for transgender men who need them as treatment for gender dysphoria, but permits cisgender women to undergo hysterectomies there for a variety of medical reasons. *See* Compl. ¶¶ 20, 26. Dignity Health canceled Mr. Minton's procedure nearly immediately after he disclosed his transgender male identity, a sequence of events that evidences intentional discrimination based on Mr.

Minton's transgender male status. Thus, the ERDs themselves operate together with Defendant's interpretation and application of them to constitute illegal sex discrimination under the Unruh Act. Defendant's application of the ERDs to deem hysterectomies impermissible sterilizations when sought by transgender men as a treatment for gender dysphoria, while permitting cisgender women to undergo hysterectomies for various medical reasons, reflects intentional, illegal sex discrimination in each instance where the policy is so applied.

Although Defendant's practices also have a disparate impact on transgender people in the aggregate, this is not the basis of Plaintiff's claim of discrimination. *See Harris v. Capital Growth Inv'rs XIV*, 52 Cal. 3d 1142, 1175 (1991) (noting that evidence of disparate impact on a protected group "may be probative of intentional discrimination in some cases"); *see also Rotary Club of Duarte v. Bd. of Dirs.*, 178 Cal. App. 3d 1035, 1046 (1986), *aff'd sub nom. Bd. of Directors of Rotary Int'l v. Rotary Club of Duarte*, 481 U.S. 537 (1987) (noting that the "Unruh Act is to be liberally construed with a view to effectuating the purposes for which it was enacted and to promote justice") .

C. Denial Of Service Is A *Per Se* Unruh Act Violation And Subsequent Conduct Does Not Excuse It.

Defendant's reliance on *North Coast Women's Care Medical Group v. San Diego Cty. Superior Ct.*, 44 Cal. 4th 1145 (2008), is misplaced, because the *North Coast* court actually rejected an attempt to assert religion as a defense to discrimination very similar to the one Defendant makes here. In *North Coast*, the plaintiff was a lesbian woman who alleged that the defendants, two physicians and the private medical practice they worked for, had denied her fertility treatment because of her sexual orientation, in violation of the Unruh Act. *Id.* at 1150-52. As discussed more fully below, the court held that none of the defendants could assert free exercise rights under the United States or California Constitution as an affirmative defense. *Id.* at 1161-62. The *North Coast* court then suggested in dicta that the defendants could potentially have avoided liability by having a different doctor within the clinic, who did not share the individual defendants' personal religious objections to the requested treatment, perform it. *Id.* at 1159 ("[D]efendant physicians can avoid . . . a conflict [between their religious beliefs and the Unruh Act's antidiscrimination provisions] by ensuring that every patient requiring [intrauterine insemination] receives 'full and equal' access to that medical procedure though [sic] a North Coast physician lacking

defendants' religious objections.") Earlier in its decision, the *North Coast* court had highlighted evidence indicating that at least two physicians working for the clinic at the relevant time had no religious objection to performing the procedure the plaintiff sought. *Id.* at 1152. In the scenario suggested[3] by the court, the clinic itself would have *provided* the treatment the plaintiff needed, and she would likely have perceived no departure from her original treatment plan other than a different doctor delivering the care.

The facts here are quite different from those of the hypothetical scenario suggested by the *North Coast* court. Mr. Minton had already been under the care of Dr. Lindsey Dawson, a physician who had no religious objection to performing his hysterectomy and in fact had made plans to perform the procedure at MSJMC on August 30. *See* Compl. ¶ 2. No physician involved with Mr. Minton's case ever raised a religious objection to personally delivering the care he needed. Rather, Dr. Dawson was abruptly informed that MSJMC had cancelled the surgery a day before she sought to perform it, because the institution as a whole was asserting a policy of refusal on religious grounds. *Id.* This unexpected rejection caused Mr. Minton great anxiety and grief. *Id.* ¶ 23. These feelings were heightened as Mr. Minton had no time to spare: he needed to undergo his hysterectomy three months prior to his subsequent phalloplasty, scheduled for November 23rd. *Id.* His surgery was then rescheduled several days later at a different hospital across town. *Id.* ¶¶ 24-25. This was not the type of accommodation suggested by the *North Coast* court, and certainly not the "full and equal" access to services required under the statute. Civ. Code. 51(b).

To the extent Defendant suggests that Mr. Minton's eventually securing access to the care he sought obviated his Unruh Act claim, this is also erroneous. Denial of service by a business establishment, like that experienced by Mr. Minton, constitutes *per se* illegal discrimination, because denying service to a member of a protected class causes that person immediate dignitary harm, and part of the purpose of civil rights laws like the Unruh Act is to protect people from such harm. *See, e.g.*,

[3] The *North Coast* court did not actually decide whether the Unruh Act would permit an individual physician within a practice to deny care to a patient on religious grounds if other physicians stepped up to provide the care, a scenario that might well constitute a violation of the Unruh Act. Further, that scenario is not before this Court, given that MSJMC as an institution refused to address Mr. Minton's medical need for a hysterectomy and thus informed his doctor that the procedure was *cancelled.*

Curran v. Mt. Diablo Council of the Boy Scouts of Am., 17 Cal. 4th 670, 705 (1998) ("[T]he purpose of section 51 in its original form was to prevent racial and other discrimination . . . primarily because of the psychological injury to those discriminated against, in the form of invasion of interests in dignity and self-respect, including interests in not being subjected to humiliation and, more generally, . . . because of the adverse overall effect of [such] discrimination on the community as a whole." (internal citations and quotation marks omitted)); *see also* Senate Commerce Comm. Report on the Civil Rights Act of 1964, S. Rep. No. 872 (1964), at 16 ("Discrimination is not simply dollars and cents, hamburgers and movies; it is the humiliation, frustration, and embarrassment that a person must surely feel when he is told that he is unacceptable as a member of the public."); *Heart of Atl. Motel, Inc. v. United States*, 379 U.S. 241, 250 (1964) (Goldberg, J., concurring) (public accommodations laws serve to "vindicate 'the deprivation of personal dignity that surely accompanies denials of equal access to public establishments.'" (citing S. Rep. No. 872 at 16-17)); *Rousseve v. Shape Spa for Health & Beauty, Inc.*, 516 F.2d 64, 67 (5th Cir. 1975) (public accommodation protections function to "eliminate the unfairness, humiliation, and insult" of discrimination "in facilities which purport to serve the general public"). The fact that Mr. Minton was eventually[4] able to undergo his surgery at a different hospital affiliated with Dignity Health does not cure the Unruh Act violation that Dignity Health committed when its staff informed Dr. Dawson that Mr. Minton's procedure had been cancelled, and that she would never be allowed to perform a hysterectomy on Mr. Minton at MSJMC, because he was a transgender man seeking the procedure as part of gender transition. *See* Compl. ¶ 22; *see generally Swanner v. Anchorage Equal Rights Comm'n*, 874 P.2d 274, 283 (Alaska 1994) ("The government views acts of discrimination as independent social evils even if the prospective tenants ultimately find housing.") Thus, by alleging that on August 29, Dignity Health informed his doctor that he would be denied treatment at MSJMC based on his transgender male identity, Mr. Minton has pled sufficient facts to demonstrate a claim for sex discrimination pursuant to the Unruh Act.

[4] Discovery will show that Dignity Health's subsequent offer to reschedule the cancelled procedure at a different hospital came in response to extensive advocacy by Mr. Minton, Dr. Dawson, his then-counsel, and others acting on his behalf.

II. Defendant Does Not Have A Constitutional Right To Discriminate Against Patients By Prohibiting Doctors From Performing Gender-Affirming Surgeries

For the reasons that follow, the allegations in the complaint fall far short of "clearly disclos[ing]" that constitutional protections bar Mr. Minton's claims. *Stella v. Asset Mgmt. Consultants, Inc.*, 8 Cal. App. 5th 181, 191 (2017). Accordingly, Defendant's demurrers should not be sustained on the basis of its purported constitutional defenses.

A. California Law Requires Religiously Affiliated Hospitals To Comply With The Unruh Act.

Defendant first argues that courts have uniformly recognized that private religious hospitals and physicians may not be compelled to perform procedures they believe to be prohibited by religious doctrine. Dem. at 2, 9-10. Defendant is incorrect.

As an initial matter, Defendant's argument misconstrues Mr. Minton's allegations. Mr. Minton's physician, Dr. Dawson, *wanted* to perform the surgery, but Defendant did not permit her to do so once Mr. Minton informed Defendant that he is a transgender man. *See* Compl. ¶¶ 2-3, 18-19, 21-22. Mr. Minton did not seek to compel any physician to perform any procedure, so the authority Defendant cites is inapplicable to this case.

Furthermore, the California Supreme Court has twice held that religiously affiliated healthcare entities must comply with California statutes mandating equitable, nondiscriminatory access to healthcare in spite of any religious objections to doing so. *See N. Coast*, 44 Cal. 4th 1145, 1158 (holding that physicians could not deny same-sex couples access to fertility procedures under the Unruh Act, because the Act is the least restrictive means for furthering "California's compelling interest in ensuring full and equal access to medical treatment irrespective of sexual orientation"); *Catholic Charities of Sacramento, Inc. v. Superior Court*, 32 Cal. 4th 527, 564–65 (2004) (holding that Catholic Charities had to comply with a state law requiring employers to include contraceptive coverage in their prescription drug plans, because "any exemption from the [law] sacrifices the affected women's interest in receiving equitable treatment with respect to health benefits"). Thus, contrary to Defendant's

contention, California courts require that a hospital's religious objections to certain forms of medical care must give way to compelling state anti-discrimination interests.[5]

B. Federal and State Constitutional Protections for Free Exercise and Free Speech Do Not Bar Mr. Minton's Claims.

Defendant next argues that Mr. Minton seeks relief that would force it to violate the ERDs and Catholic teachings. But "a religious objector has no federal constitutional right to an exemption from a neutral and valid law of general applicability on the ground that compliance with that law is contrary to the objector's religious beliefs." *N. Coast*, 44 Cal. 4th at 1155 (citing *Emp't Div. v. Smith*, 494 U.S. 872, 879 (1990)).[6] Defendant does not dispute that the Unruh Act is a neutral law of general applicability, so its constitutional arguments must fail.

Defendant is wrong that strict scrutiny is the appropriate standard to apply to its free exercise defense. Dem. at 11. Rather, the general rule is that "a law that is neutral and of general applicability need not be justified by a compelling government interest even if the law has the incidental effect of burdening a particular religious practice." *Catholic Charities*, 32 Cal. 4th at 549 (citing *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 531 (1993)) (internal quotation marks omitted); *see also Catholic Charities*, 32 Cal. 4th at 565 ("We are unaware of any decision in which this court, or the United States Supreme Court, has exempted a religious objector from the operation of a neutral, generally applicable law despite the recognition that the requested exemption would detrimentally affect the rights of third parties."). The cases Defendant cites for the supposed rule that "the California Supreme Court applies strict scrutiny" to such laws say no such thing. *See id.*, 32 Cal. 4th at 566 ("We do not hold that the state free exercise clause requires courts to apply the [strict scrutiny] test to neutral, generally applicable laws that incidentally burden religious practice. Instead, as

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[5] The ACLU is often called on to balance religious liberty with other civil liberties. Defendant cites to past ACLU briefs and testimony in an unavailing attempt to support its contention that the present case warrants abandonment of antidiscrimination principles in favor of an institutional assertion of religious liberty. While Mr. Minton need not address each of Defendant's citations, it bears noting that these documents support Mr. Minton's case.

[6] Defendant asserts that *Smith* applies only "to 'individuals,' not the Catholic Church." Dem. at 11 n.20. Yet the California Supreme Court has applied *Smith* to non-profit organizations affiliated with the Catholic Church, like Defendant. *See Catholic Charities*, 32 Cal. 4th at 548–49.

explained above, we leave that question for another day."); *N. Coast*, 44 Cal. 4th at 1158 ("[T]his case presents no need for us to determine the appropriate test.").

Second, even if strict scrutiny *were* the appropriate test, the California Supreme Court has held that state statutes aimed at preventing discrimination, such as the Unruh Act, survive even strict scrutiny under the California Constitution. *See N. Coast*, 44 Cal. 4th at 1158 ("The [Unruh] Act furthers California's compelling interest in ensuring full and equal access to medical treatment irrespective of sexual orientation, and there are no less restrictive means for the state to achieve that goal."); *see also Catholic Charities*, 32 Cal. 4th at 564–66. The *N. Coast* court's reference in *dicta* to possible strategies a medical practice group might have used to address individual physicians' religious objections in no way suggested that the Unruh Act failed strict scrutiny. *See N. Coast*, 44 Cal. 4th at 1158. Rather, that court held that even if compliance with the Unruh Act's prohibition on sexual orientation discrimination would substantially burden physicians' religious beliefs, "that burden is insufficient to allow them to engage in such discrimination." *Id.*

Third, even if the law permitted a free exercise defense in this context, Defendant cannot sustain the demurrer on that basis because it has failed to articulate any non-speculative burden on its constitutional rights that is evident on the face of the Complaint. The most that Defendant can muster is the hypothetical possibility that an order from this Court granting the requested relief "*could* lead to enforcement of the ERDs by the local Catholic Bishop" or put Defendant at "*risk* of losing its Catholic identity." Dem. at 11 & n.20 (emphasis added). This is insufficient to sustain the demurrer.

Defendant also argues that the relief Mr. Minton seeks would burden its freedom of expression. *See* Dem. at 11-12 & n.20. But the cases Defendant cites do not support its contention that the relief sought would unconstitutionally compel speech. *See* Dem. at 11-13. The *North Coast* court specifically rejected this argument, holding that "simple obedience to a law that does not require one to convey a verbal or symbolic message cannot reasonably be seen as a statement of support for the law or its purpose," because "[s]uch a rule would, in effect, permit each individual to choose which laws he would obey merely by declaring his agreement or opposition." *N. Coast*, 44 Cal. 4th at 1157. Well-settled Supreme Court doctrine instructs that purportedly compelled conduct must possess sufficient

communicative elements to merit First Amendment protection. *See Texas v. Johnson*, 491 U.S. 397, 404 (1989) (noting this inquiry depends on whether "[a]n intent to convey a particularized message was present, and [whether] the likelihood was great that the message would be understood by those who viewed it." (citations omitted)); *see also Christian Legal Soc. Chapter of the University of California, Hastings College of the Law v. Martinez*, 561 U.S. 661, 696 (2010) (refusing First Amendment protection for a student group excluding gay members, because "[e]ven if a regulation has a differential impact on groups wishing to enforce exclusionary membership policies, where the State does not target conduct on the basis of its expressive content, acts are not shielded from regulation merely because they express a discriminatory idea or philosophy." (quotations omitted)). A law requiring Defendant to cease discrimination does not compel speech merely because it requires the parties to comply. Unsurprisingly, Defendant does not cite any cases to support the proposition that the federal or California Constitutions treat denying healthcare services as a protectable expression of speech or faith—nor could it.[7] Simply obeying the law is not an unconstitutional burden to bear. *See N. Coast*, 44 Cal. 4th at 1157.

Neither would the relief Mr. Minton seeks infringe on Defendant's freedom of expressive association. Defendant devotes much attention to a series of cases involving membership in (i.e., association with) private organizations. *See Boy Scouts of Am. v. Dale*, 530 U.S. 640 (2000) (plaintiff denied membership in Boy Scouts of America); *Hurley v. Irish-Am. Gay, Lesbian & Bisexual Grp. of Boston*, 515 U.S. 557, 577 (1995) (plaintiff denied right to march in privately organized parade); *Hart v. Cult Awareness Network*, 13 Cal. App. 4th 777 (1993) (plaintiff Scientologist refused membership in Cult Awareness Network). Even if a hospital association like Defendant were deemed to be an expressive enterprise (though that is far from clear), a patient's transactional relationship with Defendant for the limited purpose of obtaining medical care – as opposed to becoming part of the organization itself – does not infringe on Defendant's freedom of expressive association. *See Rumsfeld v. Forum for*

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[7] Defendant's citations to *Kelly* and *First Covenant Church* are inapposite. *See* Dem. at 12. In *Kelly,* the issue was whether a hospital fell under a statutory religious exception in the Fair Employment and Housing Act, not whether the religiously affiliated hospital was engaging in protected expressive conduct. *See Kelly v. Methodist Hosp. of S. Cal.*, 22 Cal. 4th 1108, 1126 (2000). In *First Covenant Church*, the court held that "when the State controls the architectural 'proclamation' of religious belief inherent in its church's exterior it effectively burdens religious speech." *First Covenant Church of Seattle v. City of Seattle*, 840 P.2d 174, 182 (Wash.1992). The physical design of a space primarily dedicated to religious worship clearly implicates the expression of messages in a way dramatically different from provision of a (private) medical procedure within a hospital.

Acad. & Institutional Rights, Inc., 547 U.S. 47, 69 (2006) (noting "critical" distinction between outsiders engaging with an entity for a limited purpose, in contrast to becoming members of an entity's expressive association). Mr. Minton does not allege that Defendant refused him membership or some other associative interest. Instead, he simply seeks access to medical care at MSJMC.

Courts across the country have rejected claims of compelled expressive conduct or forced association when private entities refuse to provide goods and services on the basis of religious beliefs. *See, e.g., Gifford v. McCarthy*, 23 N.Y.S.3d 422, 432 (N.Y. App. Div. 2016) ("[T]here is no real likelihood that the Giffords would be perceived as endorsing the values or lifestyle of the individuals renting their facilities as opposed to merely complying with anti-discrimination laws."); *Craig v. Masterpiece Cakeshop, Inc.*, 370 P.3d 272, 286 (Colo. App. 2015), *cert. granted sub nom. Masterpiece Cakeshop, Ltd. v. Col. Civil Rights Comm'n*, No. 16-111, 2017 WL 2722428 (U.S. June 26, 2017); *State v. Arlene's Flowers, Inc.*, 389 P.3d 543, 557 (Wash. 2017). For example, in *Gifford*, the court held that, "[l]ike all other owners of public accommodations who provide services to the general public, the Giffords must comply with the statutory mandate prohibiting discrimination against customers on the basis of sexual orientation or any other protected characteristic." 23 NY.S.3d at 42. Under those circumstances, as here, there is "no real likelihood" that the Giffords would be perceived as endorsing the values or lifestyle of the individuals who use their facilities. *Id.* at 41-42; *see also Masterpiece Cakeshop*, 370 P.3d at 286 ("[T]he act of designing and selling a wedding cake to all customers free of discrimination does not convey a celebratory message about same-sex weddings likely to be understood by those who view it."); *Arlene's Flowers*, 389 P.3d at 557 ("The decision to either provide or refuse to provide flowers for a wedding does not inherently express a message about that wedding."). Similarly, the decision to allow hospital facilities, where a diverse range of patients receive a diverse range of health care services, to be used to perform a hysterectomy for a transgender patient does not inherently express a message about gender-affirming surgeries.

In sum, none of the allegations in the complaint makes clear that Mr. Minton's requested relief would put any unconstitutional burden on Dignity Health. Rather, Mr. Minton asks only that Defendant comply with what the law requires of all public accommodations that provide services to the general

public: full and equal access to medical treatment irrespective of gender identity. Accordingly, Defendant's affirmative defenses cannot be a basis for sustaining the demurrer.

C. The Church Autonomy Doctrine Does Not Apply Here.

Defendant also unsuccessfully invokes the church autonomy doctrine. The doctrine, rooted in the federal Establishment Clause, provides "constitutional limitations on the extent to which a civil court may inquire into and determine matters of ecclesiastical cognizance and polity in adjudicating *intrachurch* disputes." *Gen. Council on Fin. & Admin. of the United Methodist Church v. Super. Ct. of Cal.*, 439 U.S. 1369, 1372–73 (1978) (Rehnquist, C.J.) (emphasis added). In *Catholic Charities*, the California Supreme Court explicitly rejected the proposition that the church autonomy doctrine prevents courts from applying state legislation to religiously affiliated entities. *Catholic Charities*, 32 Cal. 4th at 542–43. Upholding a law that required Catholic Charities to provide contraception coverage to its employees, many of whom were not Catholic, the Court observed that applying such state legislation "does not implicate internal church governance" and does not "require [courts] to decide any religious questions," but only requires them to "apply the usual rules for assessing whether state-imposed burdens on religious exercise are constitutional." *Id.*

So too here, the Court may apply California anti-discrimination and healthcare laws to religiously affiliated hospitals without infringing upon church autonomy, or implicating that doctrine in any way. Mr. Minton's case—unlike those cited by Defendant—does not concern disputes over internal church governance, disposition of a church's property, the employment relationship between a church and its ministers, or the interactions between a pastor and members of a congregation. *See* Dem. at 14. For example, Defendant cites *Means v. U.S. Conference of Catholic Bishops*, No. 1:15–CV–353, 2015 WL 3970046 (W.D. Mich. June 30, 2015), *aff'd* 836 F.3d 643. In that case, a Michigan federal district court refused to examine whether the *Church sponsors* of a Catholic healthcare system could be held liable for its imposition of the ERDs on a Catholic hospital. *Id.* at *14. Nonetheless, the court noted that while "it must defer to religious institutions in their articulation of church doctrine and policy," the plaintiff would still have recourse to a civil lawsuit against the *hospital* because "the Court's consideration of the legal duty of a physician to provide adequate medical care is not a matter of church

doctrine." *Id.* at *13-14. Here, this Court may properly consider Defendant's legal duty to not discriminate in the provision of healthcare under California law. Mr. Minton's case is against a hospital for denying him care, not against any religious sponsor of such hospital for promoting or imposing the ERDs. Because Mr. Minton does not seek relief that would intrude upon internal church governance and management, the church autonomy doctrine does not apply.

CONCLUSION

For the foregoing reasons, the Court should deny Defendant's demurrers.

Dated: July 24, 2017

Respectfully Submitted,

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Clerk of the Court
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Deputy Clerk

**SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF SAN FRANCISCO**

EVAN MINTON,

Plaintiff,

v.

DIGNITY HEALTH; DIGNITY HEALTH d/b/a MERCY SAN JUAN MEDICAL CENTER,

Defendant

Case No. CGC 17-558259

PLAINTIFF EVAN MINTON'S REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF OPPOSITION TO DEFENDANT DIGNITY HEALTH'S DEMURRERS TO VERIFIED COMPLAINT

Hearing Date: August 15, 2017
Hearing Time: 9:30 a.m.
Dept.: 302

TO THE COURT, ALL PARTIES, AND THEIR ATTORNEYS OF RECORD:

PLEASE TAKE NOTICE THAT Plaintiff Evan Minton hereby requests judicial notice of the following pursuant to California Evidence Code Section 452(h). The materials listed below are relevant to arguments made in the Verified Complaint and in the Opposition to Defendant Dignity Health's Demurrers to the Verified Complaint.

1. An excerpt from the Seventh Version of the World Professional Association of Transgender Health ("WPATH") Standards of Care, which are "recognized as authoritative standards of care by the American Medical Association, the American Psychiatric Association, and the American Psychological Association." *See Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1170 (N.D. Cal. 2015), *appeal dismissed and remanded*, 802 F.3d 1090 (9th Cir. 2015).

Judicial notice is proper under Evidence Code Section 452(h), which permit courts to take judicial notice of "[f]acts and propositions that are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy."

Dated: July 24, 2017

Respectfully Submitted,

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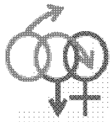
EXHIBIT 1



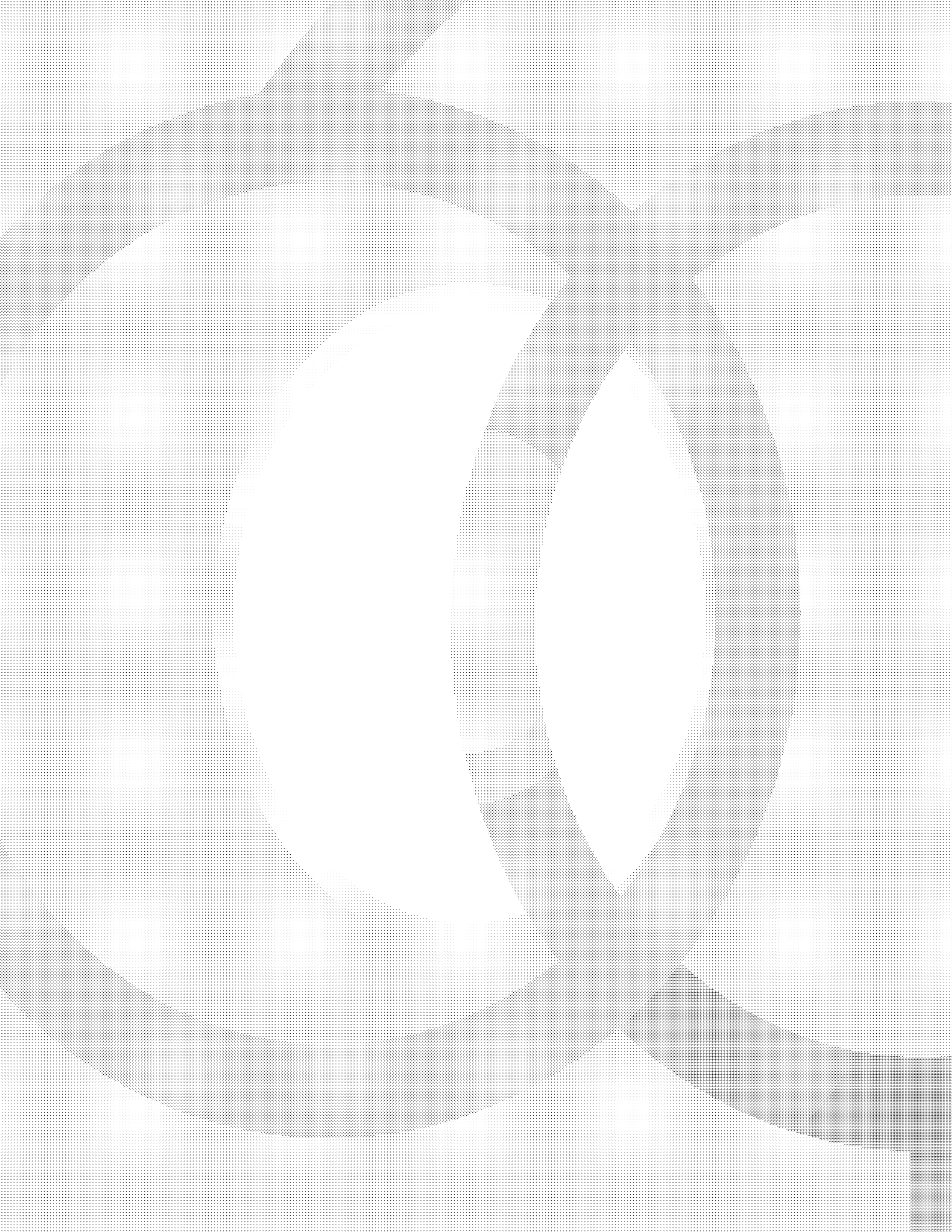
Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health

www.wpath.org

7th Version



Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

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The World Professiona Association for Transgender Health

7th Version[1] | www.wpath.org

1 This is the seventh version of the Standards of Care. The original SOC were published in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001.

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I

Purpose and Use of the Standards of Care

The World Professional Association for Transgender Health (WPATH)[1] is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The *SOC* are based on the best available science and expert professional consensus.[2] Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the *SOC* to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the *SOC*.

The overall goal of the *SOC* is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the *SOC* may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

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1 Formerly the Harry Benjamin International Gender Dysphoria Association

2 *Standards of Care (SOC), Version 7* represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

The Standards of Care Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As for all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

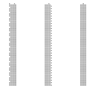
Global Applicability of the Standards of Care

While the *SOC* are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the *SOC* to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the *SOC* according to local realities. For example, in a number of cultures, gender nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens, or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender nonconforming people in these settings are forced to be hidden, and therefore may lack opportunities for adequate health care (Winter, 2009).

The *SOC* are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world – even in areas with limited resources and training opportunities – can apply the many core principles that undergird the *SOC*. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culturally and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the *SOC* are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.



The Difference Between Gender Nonconformity and Gender Dysphoria

Being Transsexual, Transgender, or Gender Nonconforming Is a Matter of Diversity, Not Pathology

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative."

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in "minority stress" (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one's relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender nonconforming.

Gender Nonconformity Is Not the Same as Gender Dysphoria

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender nonconforming people may experience gender dysphoria at some point in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases* (*ICD*) (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

Thus, transsexual, transgender, and gender nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

IV

Epidemiologic Considerations

Formal epidemiologic studies on the incidence[3] and prevalence[4] of transsexualism specifically or transgender and gender nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria – distinct from one's gender identity – is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European

3 **incidence**—the number of new cases arising in a given period (e.g., a year)
4 **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

communication treatment can be considered in developing an individualized therapy plan (Carew, Dacakis, & Oates, 2007; Dacakis, 2000; Davies & Goldberg, 2006; Gelfer, 1999; McNeill, Wilson, Clark, & Deakin, 2008; Mount & Salmon, 1988).

Feminizing or masculinizing the voice involves non-habitual use of the voice production mechanism. Prevention measures are necessary to avoid the possibility of vocal misuse and long-term vocal damage. All voice and communication therapy services should therefore include a vocal health component (Adler et al., 2006).

Vocal Health Considerations after Voice Feminization Surgery

As noted in section XI, some transsexual, transgender, and gender nonconforming people will undergo voice feminization surgery. (Voice deepening can be achieved through masculinizing hormone therapy, but feminizing hormones do not have an impact on the adult MtF voice.) There are varying degrees of satisfaction, safety, and long-term improvement in patients who have had such surgery. It is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication. Voice surgery procedures should include follow-up sessions with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists in that country (Kanagalingam et al., 2005; Neumann & Welzel, 2004).

XI
Surgery_

Sex Reassignment Surgery Is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage

& Karim, 2000). For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. Moreover, surgery can help patients feel more at ease in the presence of sex partners or in venues such as physicians' offices, swimming pools, or health clubs. In some settings, surgery might reduce risk of harm in the event of arrest or search by police or other authorities.

Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Gijs & Brewaeys, 2007; Klein & Gorzalka, 2009; Pfäfflin & Junge, 1998). Additional information on the outcomes of surgical treatments are summarized in Appendix D.

Ethical Questions Regarding Sex Reassignment Surgery

In ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply.

It is important that health professionals caring for patients with gender dysphoria feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort and distress of individuals with gender dysphoria, professionals need to listen to these patients discuss their symptoms, dilemmas, and life histories. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments.

Genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in section VII of the *SOC*. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and of course patients, share responsibility for the decision to make irreversible changes to the body.

It is unethical to deny availability or eligibility for sex reassignment surgeries solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis C or B.

Relationship of Surgeons with Mental Health Professionals, Hormone-Prescribing Physicians (if Applicable), and Patients (Informed Consent)

The role of a surgeon in the treatment of gender dysphoria is not that of a mere technician. Rather, conscientious surgeons will have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must talk at length with their patients and have close working relationships with other health professionals who have been actively involved in their clinical care.

Consultation is readily accomplished when a surgeon practices as part of an interdisciplinary health care team. In the absence of this, a surgeon must be confident that the referring mental health professional(s), and if applicable the physician who prescribes hormones, are competent in the assessment and treatment of gender dysphoria, because the surgeon is relying heavily on their expertise.

Once a surgeon is satisfied that the criteria for specific surgeries have been met (as outlined below), surgical treatment should be considered and a preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatments for gender dysphoria:

- The different surgical techniques available (with referral to colleagues who provide alternative options);
- The advantages and disadvantages of each technique;
- The limitations of a procedure to achieve "ideal" results; surgeons should provide a full range of before-and-after photographs of their own patients, including both successful and unsuccessful outcomes;
- The inherent risks and possible complications of the various techniques; surgeons should inform patients of their own complication rates with each procedure.

These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Ensuring that patients have a realistic expectation of outcomes is important in achieving a result that will alleviate their gender dysphoria.

All of this information should be provided to patients in writing, in a language in which they are fluent, and in graphic illustrations. Patients should receive the information in advance (possibly via the internet) and given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the patient. Because these surgeries are irreversibile, care should be taken to ensure that patients have sufficient time to absorb information fully before they are asked to provide informed consent. A minimum of 24 hours is suggested.

Surgeons should provide immediate aftercare and consultation with other physicians serving the patient in the future. Patients should work with their surgeon to develop an adequate aftercare plan for the surgery.

Overview of Surgical Procedures for the Treatment of Patients with Gender Dysphoria

For the male-to-female (MtF) patient, surgical procedures may include the following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);
2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;
3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

For the female-to-male (FtM) patient, surgical procedures may include the following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;
2. Genital surgery: hysterectomy/ovariectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

Reconstructive Versus Aesthetic Surgery

The question of whether sex reassignment surgery should be considered "aesthetic" surgery or "reconstructive" surgery is pertinent not only from a philosophical point of view, but also from a financial point of view. Aesthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient. In contrast, reconstructive procedures are considered medically necessary – with unquestionable therapeutic results – and thus paid for partially or entirely by national health systems or insurance companies.

Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.

While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

Criteria for Surgeries

As for all of the *SOC*, the criteria for initiation of surgical treatments for gender dysphoria were developed to promote optimal patient care. While the *SOC* allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one's gender identity.

These criteria are outlined below. Based on the available evidence and expert clinical consensus, different recommendations are made for different surgeries.

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SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF SAN FRANCISCO

EVAN MINTON Plaintiff, v. DIGNITY HEALTH; DIGNITY HEALTH d/b/a MERCY SAN JUAN MEDICAL CENTER Defendant.	Case No. CGC 17-558259 **PROOF OF SERVICE** Department: 302 Hearing Date: August 15, 2017 Hearing Time: 9:30 a.m.

PROOF OF SERVICE

I am a citizen of the United States. My business address is One Front Street, San Francisco, California 94111. I am employed in the City and County of San Francisco where this service takes place. I am over the age of 18 years, and not a party to the within cause. I am readily familiar with my employer's normal business practice for collection and processing of correspondence. On the date set forth below, I served the following document(s) described as:

- **PLAINTIFF EVAN MINTON'S MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO DEFENDANT DIGNITY HEALTH'S DEMURRERS TO VERIFIED COMPLAINT**
- **PLAINTIFF EVAN MINTON'S REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF OPPOSITION TO DEFENDANT DIGNITY HEALTH'S DEMURRERS TO VERIFIED COMPLAINT**
- **PROOF OF SERVICE**

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[X] (By NOTICE OF ELECTRONIC FILING) I electronically filed the document(s) with the Clerk of the Court by using File and Serve Express. Participants in the case who are registered File and Serve Express users will be served by the File and Serve Express system. Participants in this case who are not registered File and Serve Express users will be served by mail or by other means permitted by the court rules.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this declaration was executed on July 24, 2017, at San Francisco, California.

Theodore Karch