IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE et al., Plaintiffs, v. JOSEPH A. LADAPO et al., Defendants.	Civil No. 4:23-cv-00114-RH-MAF

EXPERT DECLARATION OF DANIEL SHUMER, M.D.

I, Daniel Shumer, M.D., hereby declare and state as follows:

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

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

I. BACKGROUND AND QUALIFICATIONS

A. Qualifications

3. I am a Pediatric Endocrinologist, Associate Professor of Pediatrics, and the Clinical Director of the Child and Adolescent Gender Clinic at Mott Children's Hospital at Michigan Medicine. I am also the Medical Director of the

Comprehensive Gender Services Program at Michigan Medicine, University of Michigan which coordinates care the provided to adult patients across our health system.

4. I am Board Certified in Pediatrics and Pediatric Endocrinology by the American Board of Pediatrics and licensed to practice medicine in the state of Michigan.

5. I received my medical degree from Northwestern University in 2008. After completing a Residency in Pediatrics at Vermont Children's Hospital, I began a Fellowship in Pediatric Endocrinology at Harvard University's Boston Children's Hospital. As a Fellow at Harvard, I trained at the Gender Management Services Clinic (GeMS) at Boston Children's Hospital where I became a clinical expert in the field of transgender medicine within Pediatric Endocrinology and began conducting research on gender identity, gender dysphoria, and the evaluation and management of gender dysphoria in children, adolescents, and young adults. Concurrent with the Fellowship, I completed a Master of Public Health from Harvard's T.H. Chan School of Public Health. I completed both the Fellowship and the MPH degree in 2015.

6. I have extensive experience in working with and treating children, adolescents, and young adults with endocrine conditions including differences in sex development (DSD) (also referred to as intersex conditions), gender dysphoria, type 1 diabetes, thyroid disorders, growth problems, and delayed or precocious puberty. I have been treating pediatric and young adult patients with gender dysphoria since

2015.

7. A major focus of my clinical, teaching, and research work pertains to the assessment and management of transgender adolescents and young adults.

8. I have published extensively on the topic of gender identity and the treatment of gender dysphoria, as well as reviewed the peer-reviewed literature concerning medical treatments for gender dysphoria, the current standards of care for the treatment of gender dysphoria, and research articles on a variety of topics with a focus on mental health in transgender adolescents and young adults.

9. I am involved in the education of medical trainees. I am the Course Director for a medical student elective in Transgender Medicine. My additional academic duties as an Associate Professor include teaching several lectures, including those entitled "Puberty," "Transgender Medicine," and "Pediatric Growth and Development."

10. Based on my work at GeMS, I was recruited to establish a similar program assessing and treating gender diverse and transgender children and adolescents at the C.S. Mott Children's Hospital in Ann Arbor. In October 2015, I founded the hospital's Child and Adolescent Gender Services Clinic.

11. The Child and Adolescent Gender Services Clinic has treated over 600 patients since its founding. The clinic provides comprehensive assessment, and when

appropriate, treatment with pubertal suppression and hormonal therapies, to patients diagnosed with gender dysphoria. I have personally evaluated and treated over 400 patients with gender dysphoria. Most of the patients receiving care range between 10 and 24 years old. Most patients attending clinic live in Michigan or Ohio. As the Clinical Director, I oversee the clinical practice, which currently includes 4 physicians (including 1 psychiatrist), 1 nurse practitioner, 2 social workers, 1 research coordinator, as well as nursing and administrative staff. I also actively conduct research related to transgender medicine, gender dysphoria treatment, and mental health concerns specific to transgender youth.

12. I also provide care in the Differences/Disorders of Sex Development (DSD) Clinic at Michigan Medicine at Mott Children's Hospital. The DSD Clinic is a multidisciplinary clinic focused on providing care to infants and children with differences in the typical path of sex development, which may be influenced by the arrangement of sex chromosomes, the functioning of our gonads (i.e. testes, ovaries), and our bodies' response to hormones. The clinic is comprised of members from Pediatric Endocrinology, Genetics, Psychology, Urology, Gynecology, Surgery, and Social Work. In this clinic I have assessed and treated over 100 patients with DSD. In my role as Medical Director of the Comprehensive Gender Services Program (CGSP), I lead Michigan Medicine's broader efforts related to transgender services. CGSP is comprised of providers from across the health system including pediatric care, adult

hormone provision, gynecologic services, adult surgical services, speech/language therapy, mental health services, and primary care. I run monthly meetings with representatives from these areas to help coordinate communication between Departments. I coordinate strategic planning aimed to improve care within the health system related to our transgender population. I also serve as the medical representative for CGSP in discussions with health system administrators and outside entities.

13. I have authored numerous peer-reviewed articles related to treatment of gender dysphoria. I have also co-authored chapters of medical textbooks related to medical management of transgender patients. I have been invited to speak at numerous hospitals, clinics, and conferences on topics related to clinical care and standards for treating transgender children and youth.

14. The information provided regarding my professional background, experiences, publications, and presentations is detailed in my curriculum vitae, a true and correct copy of the most up-to-date version of which is attached as **Exhibit A**.

B. Prior Testimony

15. In the past four years, I have been retained as an expert and provided testimony at trial or by deposition in the following cases: *Dekker v. Weida*, No. 4:22-cv-00325 (N.D. Fla.); *K.C. v. The Individual Members of the Medical Licensing Board of Indiana*, No. 1:23-cv-00595 (S.D. Ind.); *Boe v. Marshall*, No. 2:22-cv-184 (M.D. Ala.); *Roe et al v. Utah High School Activities Association et al* (Third District Court

in and for Salt Lake County, UT); *Menefee v. City of Huntsville Bd. of Educ.*, No. 5:18-cv-01481 (N.D. Ala.); and *Cooper v. USA Powerlifting and Powerlifting Minnesota*, No. 62-CV-21-211 (Ramsey Cnty. Dist. Ct., Minn.). I also provided expert witness testimony on behalf of a parent in a custody dispute involving a transgender child in the following case: *In the Interest of Younger*, No. DF-15-09887 (Dallas County, Texas).

C. Compensation

16. I am being compensated at an hourly rate for the actual time that I devote to this case, at the rate of $325 per hour for any review of records, preparation of reports, declarations, and deposition and trial testimony. My compensation does not depend on the outcome of this litigation, the opinions that I express, or the testimony that I provide.

D. Bases for Opinions

17. In preparing this declaration, I reviewed the text of documents adopted by the Florida Board of Medicine titled, "Masculinizing Medications for Patients with Gender Dysphoria: Patient Information and Informed Consent" (DH5082-MQA, Rev. 06/23) and "Feminizing Medications for Patients with Gender Dysphoria: Patient Information and Informed Consent" (DH5083-MQA, Rev. 06/23).

18. I have also reviewed the materials listed within my curriculum vitae, which is attached as **Exhibit A** to this report, as well as the materials listed in the

bibliography attached as **Exhibit B**. The sources cited therein include authoritative, scientific peer-reviewed publications. They include the documents specifically cited as supportive examples in particular sections of this report. I may rely on these materials as additional support for my opinions.

19. In addition, I have relied on my scientific education, training, and years of clinical and research experience, and my knowledge of the scientific literature in the pertinent fields.

20. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on these subjects.

21. To the best of my knowledge, I have not met or spoken with the Plaintiffs in related litigation. My opinions are based solely on my extensive background and experience treating transgender patients.

22. I may wish to supplement or revise these opinions or the bases for them due to new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

II. THE BOARD'S INFORMED CONSENT DOCUMENTS ARE MEDICALLY INACCURATE, IMPOSE MEDICALLY UNWARRANTED AND HARMFUL REQUIREMENTS, AND UNDERMINE RATHER THAN FACILIATE INFORMED CONSENT

23. The consent forms created by the Florida Board of Medicine are

inappropriate because they provide incorrect information, mandate inappropriate restrictions on care, and create harmful barriers to patients getting the care they need.

24. Health care professionals have both a legal and ethical obligation to ensure that patients receive accurate information about medical treatments they are prescribed. This includes a discussion of the medical condition being treated, potential treatment options, and potential risks and benefits of those treatment options. Providers must ensure that patients have the capacity to understand these discussions and that they agree to the treatment plan. Because the forms state inaccurate information, require unnecessary restrictions on care, and falsely describe the risk/benefit ratio, these forms undermine the process of informed consent rather than facilitate it.

25. How health care professionals undertake the informed consent process is tailored to the medical context and the individual patient-provider relationship. Most medical decision making does not involve signing a consent form. For example, when a patient is diagnosed with diabetes, very few if any endocrinologists utilize an informed consent document prior to starting insulin even though there are significant risks associated with insulin in management of diabetes. That said, physicians may use written consent forms in a situation where they believe the form will facilitate discussion of a complex medical decision, enhance patient understanding of the intervention, or provide formal documentation that the material was reviewed with the patient. There may be, for example, providers in Florida who will decide to employ a

written consent form prior to prescribing masculinizing or feminizing hormonal therapy. In so doing, they are using the consent form as a tool to improve patient care.

26. When a regulatory agency interferes with the informed consent process to require doctors to misstate information, impose medically unsupported requirements, and create unnecessary barriers to ongoing care, the process is corrupted and patient autonomy is undermined. Nowhere is this more apparent than in the consent form itself: *"The Florida Board of Medicine or the Florida Board of Osteopathic Medicine requires that your prescribing physician provide this form in accordance with section 456.54, F.S. This form contains information required to be disclosed to you by Florida law and does not necessarily reflect the views or opinions of your physician."* The layman's translation: the Florida legislature wants to let you know that we disagree with the decision you and your doctor are making together.

27. The consent forms are intended for use in patients with gender dysphoria considering a hormonal intervention. The goal of any intervention for gender dysphoria is to reduce dysphoria and improve functioning. Clinical practice guidelines have been published by several long-standing and well-respected medical bodies: the World Professional Association for Transgender Health (WPATH) and the Endocrine Society (Coleman, et al., 2022; Coleman, et al., 2012; Hembree, et al., 2017; Hembree, et al., 2009), as well as the UCSF Center for Excellence in Transgender Health (Deutsch (ed.), 2016). The clinical practice guidelines and standards of care published

by these organizations provide a medically sound, evidence-based framework for treatment of gender dysphoria in adults. These resources provide the context for my more specific comments related to the content of the consent forms.

III. THE "MASCULINIZING MEDICATIONS" FORM

28. Prior to a line-item discussion, it is important to point out that in several instances this form describes certain requirements which are medically inappropriate, have no utility, and serve only as a barrier to care. I will point these examples out alongside my discussion of other problems.

29. The statement in the informed consent forms that says when hormone therapies are prescribed for gender dysphoria they are not being "used for their intended purpose" is inaccurate, misleading and is likely to confuse patients. Off-label use is common. The FDA itself has said that once FDA has approved medications, doctors can prescribe such medications if they judge them to be appropriate for their patients. Many medications are prescribed for off-label uses. That does not mean "they are not being used for their intended purposes."

30. Page 1, Paragraph 4 (Medical treatment…): This paragraph undermines the patient's ability to make an informed decision by giving the patient incorrect and biased information. Describing medical treatment of gender dysphoria as being based on very limited, poor-quality research is incorrect and misleading. Medical evidence supports the treatment of gender dysphoria with hormonal care when appropriate, as I

have testified to extensively before this court in *Dekker v. Weida*. In addition, far from being "purely speculative," this care is well-established and based on substantial data and decades of clinical experience.

31. Page 3, Paragraph 2 (Before beginning…): The requirement to undergo evaluation by a Florida licensed psychiatrist or psychologist prior to starting hormone replacement therapy (HRT) and every two years after demonstrates a profound lack of understanding of gender identity and dysphoria and of how health care is provided in our country; there is no medical justification for this requirement, which serves only as an unnecessary and potentially insurmountable barrier to care. The health care professional most appropriate to assess a patient's readiness for HRT is one who has clinical expertise and experience working with gender diverse patients. As the WPATH Standards of Care recognize, this may very well be a psychiatrist or psychologist, but may also be a therapist or social worker, a primary care physician, or another health care professional fluent in these topics and available to meet with the patient to have detailed discussion of their experience with gender.

32. In Ann Arbor where I practice, for example, I know of no psychiatrist or psychologist that performs these types of assessments. The assessment of gender dysphoria is primarily the role of therapists and social workers. If every transgender adult in Michigan (and I would presume, in Florida) required a visit with a psychiatrist or psychologist every two years, there would be no logistical way for this to occur due

to lack of access. It is also not medically necessary. Psychiatrists, since they can prescribe psychotropic medications, are critical for patients with mental health problems requiring psychotropic drugs. I would refer a transgender patient to a psychiatrist, for example, if they needed assessment and management of bipolar disorder. But there is no similar medical justification for requiring a psychiatrist to approve the use of HRT.

33. As outlined above, mandating that a transgender patient be evaluated by a psychiatrist or psychologist before starting HRT is inappropriate, but requiring the patient to undergo such an evaluation every two years, to *continue* treatment, compounds the harm caused by this unnecessary requirement, which serves no function that advances either patient care or patient informed consent.

34. More generally, the requirement that transgender patients undergo lifelong therapy has no medical basis. While mental health support can be helpful to many patients, with and without gender dysphoria, the Standards of Care do not require lifelong therapy, and there is no medical justification for such a requirement. Accordingly, it is far outside the scope of informed consent to require treatment that is not necessary for care of a medical condition and doing so will keep people from getting the essential medical care they need.

35. The additional requirement that the psychiatrist or psychologist must be licensed in Florida adds another irrational, arbitrary, and harmful barrier. There is no

reason that a transgender patient who was diagnosed by an appropriate healthcare provider in another state should have to be re-evaluated by a provider licensed in Florida.

36. In short, this provision of the informed consent form has no basis in medicine and does not provide patient information or promote informed consent in any sense. It is a substantive requirement not essential or even related to the informed consent process and serves only as a barrier to care.

37. Page 3, Paragraph 1 (Testosterone is . . .): This paragraph accurately states that testosterone is not typically given as a pill. It then, however, goes on to discuss "fatal liver problems" associated with a medication that the physician is not going to prescribe. This approach of needlessly scaring patients undermines rather than enhances informed consent.

38. Page 1, Paragraph 1 (Before starting…): As outlined above, mandating the use of this form prior to starting therapy is inappropriate, but requiring it over-and-over, to *continue* treatment, serves no function that advances either patient care or patient informed consent. The effect of having a patient sign a form multiple times that states the information creates an unnecessary barrier to the care.

39. Page 2, Paragraph 2 (Finasteride is…): Finasteride is a drug that can be used by any person with male-pattern baldness. The medical term for this is androgenic alopecia. A transgender man would only be prescribed this drug if he were having

baldness and was bothered by it, just as would be true for a non-transgender man. It is not part of the course of treatment for gender dysphoria. There is no medical justification for requiring signed informed consent by a transgender man for a drug prescribed to combat baldness which he may or may not need and which could be prescribed for either transgender or non-transgender men.

40. Page 4, Paragraph 1 (The following…). There is no medical basis for the list of items included in Page 4, Paragraph 1. Their inclusion serves only to confuse and undermine informed consent and to create unnecessary obstacles to care. Patients receiving care for gender dysphoria are diverse and have different needs. Patients doing very well may need to be seen less frequently than patients who are struggling. Patients with other medical conditions, such as diabetes or hyperlipidemia, may need lab evaluation more frequently than other patients with no medical problems. Dictating visit frequency, frequency of mental health screening, and laboratory and radiology testing is not an appropriate role for a State Medical Board. These are decisions that medical providers make while thinking critically about each individual patient.

41. Page 6, Row 3: This statement is incorrect, "[T]here is no data in the medical literature or controlled research studies that support the timing, dosing, and type of administration of HRT." In fact, there are well-established published guidelines that include timing, dosing, and type of administration of hormone therapy and that are supported by research data. (Hembree, et al., 2017; Deutsch (ed.), 2016).

42. The item in this section that stands out to me as the most egregious is annual bone scans for 5 years. Testosterone does not cause diminution in bone density; it may increase bone density slightly or have no impact. (Rothman and Iwamoto (2019). There is no medical reason to consider DEXA scans for all transmasculine patients starting testosterone. In addition, doing annual DEXA scans for *any* reason is illogical. DEXA scans measure bone density and the test is primarily used to assess for osteoporosis in older adults. Changes to bone density occur very slowly and therefore doing annual DEXA scans is not helpful; a year is not enough time to see meaningful change. In fact, most insurance plans that I am familiar with refuse to pay for DEXA scan in adults more frequently than every 2 years for this reason—there is no clinical reason to do this *even in people with osteoporosis*. The statement in the consent forms related to DEXA scans is a clear tell that the form was written by someone without familiarity with the material, that would result in millions of dollars of unnecessary health care utilization, and that creates a hindrance to transgender patients getting essential care for treatment of gender dysphoria.

43. Summary Table: This table provides a good example about why this type of document is problematic. For each patient, there may be particular risks that I want to focus on related to their situation. For example, in the case of a patient already dealing with significant acne, I would discuss a specific acne plan for them while starting testosterone, but I would be much less concerned about their risk for an

"inflamed liver" as this is something that I have never seen occur in my clinical practice. Presenting a patient with a laundry list of risks and benefits with no information about how to assess their likelihood undermines a patient's ability to make an informed medical choice.

44. Masculinizing Effects Table, Row 4 (The following changes could be…). This row lists all the non-permanent effects of testosterone. Saying that any of these effects could be permanent is incorrect.

45. Risks of Testosterone and Estrogen Tables. As set forth above, presenting a laundry list of risks with no information about how to assess their likelihood undermines a patient's ability to make an informed medical choice.

46. In addition, I want to highlight two rows that are inaccurate. Data does not support the assertion that "treatment with testosterone increases the risk of cancer to the uterus, ovaries, or breasts," and "taking testosterone causes or worsens migraines." The inclusion of these "risks" has no medical basis.

IV. THE "FEMINIZING MEDICATIONS" FORM

47. Because this form parallels the masculinizing form and uses identical language in many sections, I will only include here items that are unique to this form.

48. Page 2, Paragraph 2 (Cyproterone acetate…). Cyproterone acetate is not available in the United States and therefore should not be included in the consent form. Including a medication that is not available only serves to engender confusion and fear.

It does not serve any legitimate purpose and deters patients from getting the care they need.

49. Page 2, Paragraphs 3 and 4. The first four paragraphs on page two include paragraphs related to medications that may or may not be prescribed to the patient. A statement in a consent form that says "various forms of progestins may also be used," provides no meaningful information and serves only to overwhelm and confuse.

50. Page 2, Paragraph 3 (The administration of finasteride …): The form states that finasteride "is not recommended for routine use in treating populations with gender dysphoria." While finasteride is not prescribed for treating gender dysphoria in transgender men, finasteride *may* be prescribed to treat gender dysphoria in transgender women in certain situations when other anti-androgens not effective, and—contrary to the implications of the form's statement—there is nothing inappropriate or unsafe about such usage.

51. Page 4, related to DEXA scans in transgender women: I know of no medically supported reason to require annual DEXA scans just because a patient is a transgender woman prescribed estrogen.

52. Page 5, related to risk of breast cancer may significantly increase if a patient takes estrogen: A transgender woman receiving estrogen has a higher risk of breast cancer compared to men but not higher than other women. In fact, this risk is

lower than that for non-transgender women. Therefore, transgender women are recommended to follow the same breast cancer mammogram screening guidelines as non-transgender women; they do not require stricter monitoring. (de Block et al. 2019).

V. OTHER RESTRICTIONS IMPOSED BY SB 254 HAVE NO MEDICAL BASIS AND WILL SERVE ONLY TO DETER TRANSGENDER PATIENTS FROM OBTAINING NEEDED MEDICAL CARE

53. S.B. 254 arbitrarily and needlessly prohibits advanced practice registered nurses ("APRNs") from prescribing and administering hormone therapy for transgender patients. As the WPATH Standards of Care recognize, there is no medical basis for this restriction, which will serve only to make it difficult or impossible for many transgender patients to receive care.

54. Prescribing and administering hormone therapy to transgender patients to treat gender dysphoria is part of primary care. The education and training that APRNs amply qualifies them to provide this care to transgender patients.

55. S.B. 254 also arbitrarily and needlessly requires that transgender patients may not receive transition-related medical case unless a physician obtains their written consent in an *in-person* meeting. In addition to the many other problems with the informed consent requirements, which I outline above, this requirement has no medical basis and serves only to erect another arbitrary and harmful barrier to care. There is nothing about discussing the risks and benefits of treatments with transgender patients and obtaining their informed consent that requires this to be done in an in-person visit,

as opposed to a video or audio meeting. This requirement is not imposed for any other patients, including those receiving medications that pose far greater risks, as well as those receiving the same medications for other purposes; there is no reason to impose it only upon transgender patients.

VI. CONCLUSION

56. The informed consent forms required by the State Boards of Medicine and Osteopathic Medicine state misinformation about care, create unsupported requirements for ongoing treatment, undermine rather than advance informed consent, and create unjustified and harmful barriers to care.

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

Executed this 24th day of July 2023.

_____

Daniel Shumer, M.D.

Exhibit A

Curriculum Vitae

Daniel Shumer, MD MPH

Clinical Associate Professor in Pediatrics - Endocrinology

Email: dshumer@umich.edu

EDUCATION AND TRAINING

Education

08/2000-08/2003	BA, Northwestern University, Evanston, United States
08/2004-05/2008	MD, Northwestern University, Feinberg School of Medicine, Chicago, United States
07/2013-05/2015	MPH, Harvard T.H. Chan School of Public Health, Boston, United States

Postdoctoral Training

06/2008-06/2011	Residency, Pediatrics, Vermont Children's Hospital at Fletcher Allen Health Care, Burlington, VT
07/2011-06/2012	Chief Resident, Chief Resident, Vermont Children's Hospital at Fletcher Allen Health Care, Burlington, VT
07/2012-06/2015	Clinical Fellow, Pediatric Endocrinology, Boston Children's Hospital, Boston, MA

CERTIFICATION AND LICENSURE

Certification

10/2011-Present	American Board of Pediatrics, General

Licensure

08/2015-Present	Michigan, Medical License
09/2015-Present	Michigan, DEA Registration

09/2015-Present Michigan, Controlled Substance

WORK EXPERIENCE

Academic Appointment

10/2015-9/2022 Clinical Assistant Professor in Pediatrics - Endocrinology, University of Michigan - Ann Arbor, Ann Arbor

09/2022-Present Clinical Associate Professor in Pediatrics - Endocrinology, University of Michigan - Ann Arbor, Ann Arbor

Administrative Appointment

07/2019-Present Fellowship Director - Pediatric Endocrinology, Michigan Medicine, Department of Pediatrics, Ann Arbor

07/2020-Present Medical Director of the University of Michigan Comprehensive Gender Services Program, Michigan Medicine, Ann Arbor

Oversee the provision of care to transgender and gender non-conforming patients at Michigan Medicine.

07/2020-Present Education Lead - Pediatric Endocrinology, University of Michigan - Department of Pediatrics, Ann Arbor

Clinical Appointments

04/2022-05/2023 Medical Director in UMMG Faculty Benefits Appt., University of Michigan - Ann Arbor, Ann Arbor

Private Practice

08/2013-09/2015 Staff Physician, Harvard Vanguard Medical Associates, Braintree

RESEARCH INTERESTS

- Gender dysphoria
- Prader Willi Syndrome

CLINICAL INTERESTS

- Gender dysphoria
- Disorders of Sex Development
- Prader Willi Syndrome

GRANTS

Past Grants

A Phase 2b/3 study to evaluate the safety, tolerability, and effects of Livoletide (AZP-531), an unacylated ghrelin analog, on food-related behaviors in patients with Prader-Willi syndrome

Millendo Therapeutics
04/2019 - 04/2021

HONORS AND AWARDS

National

2014	Annual Pediatric Endocrine Society Essay Competition: Ethical Dilemmas in Pediatric Endocrinology: competition winner - The Role of Assent in the Treatment of Transgender Adolescents

Institutional

2012 - 2015	Harvard Pediatric Health Services Research Fellowship; funded my final two years of pediatric endocrine fellowship and provided tuition support for my public health degree

2016	The University of Michigan Distinguished Diversity Leaders Award, awarded by The Office of Diversity, Equity and Inclusion to the Child and Adolescent Gender Services Team under my leadership
2019	Lecturer of the Month, Department of Pediatrics, Michigan Medicine

TEACHING MENTORSHIP

Resident

07/2020-Present	Rebecca Warwick, Michigan Medicine (co-author on publication #22)

Clinical Fellow

07/2017-06/2020	Adrian Araya, Michigan Medicine (co-author on publication #22, book chapter #4)
12/2020-Present	Jessica Jary, Michigan Medicine - Division of Adolescent Medicine

Medical Student

09/2017-06/2020	Michael Ho, Michigan Medicine
07/2019-Present	Hadrian Kinnear, University of Michigan Medical School (co-author on book chapter #3, abstract #3)
07/2019-Present	Jourdin Batchelor, University of Michigan

TEACHING ACTIVITY

Regional

08/2018-Present	Pediatric Boards Review Course sponsored by U-M: “Thyroid Disorders and Diabetes”. Ann Arbor, MI

Institutional

12/2015-12/2015	Pediatric Grand Rounds: "Transgender Medicine - A Field in Transition". Michigan Medicine, Ann Arbor, MI
02/2016-02/2016	Medical Student Education: Panelist for M1 Class Session on LGBT Health, Doctoring Curriculum. Michigan Medicine, Ann Arbor, MI
02/2016-02/2016	Psychiatry Grand Rounds: "Transgender Medicine - A Field in Transition". Michigan Medicine, Ann Arbor, MI
03/2016-03/2017	Pharmacy School Education: "LGBT Health". University of Michigan School of Pharmacy, Ann Arbor, MI
04/2016-Present	Course Director: Medical Student (M4) Elective in Transgender Medicine. Michigan Medicine, Ann Arbor, MI
04/2016-04/2016	Rheumatology Grand Rounds: "Gender Identity". Michigan Medicine, Ann Arbor, MI
05/2016-05/2016	Lecture to Pediatric Rheumatology Division: "Gender Dysphoria". Michigan Medicine, Ann Arbor, MI
07/2016-07/2016	Internal Medicine Resident Education: "Gender Identity". Michigan Medicine, Ann Arbor, MI
09/2016-09/2016	Presentation to ACU Leadership: "Gender Identity Cultural Competencies". Michigan Medicine, Ann Arbor, MI
10/2016-10/2016	Presentation to Department of Dermatology: "The iPledge Program and Transgender Patients". Michigan Medicine, Ann Arbor, MI
02/2017-02/2017	Swartz Rounds Presenter. Michigan Medicine, Ann Arbor, MI
02/2017-02/2017	Lecture to Division of General Medicine: "Transgender Health". Michigan Medicine, Ann Arbor, MI

02/2017-02/2017	Presentation at Collaborative Office Rounds: "Transgender Health". Michigan Medicine, Ann Arbor, MI
10/2017-10/2017	Family Medicine Annual Conference: "Transgender Medicine". Michigan Medicine, Ann Arbor, MI
12/2017-12/2017	Presenter at Nursing Unit 12-West Annual Educational Retreat: "Gender Identity at the Children's Hospital". Michigan Medicine, Ann Arbor, MI
02/2018-Present	Pediatrics Residency Lecturer: "Puberty". Michigan Medicine, Ann Arbor, MI
02/2019-Present	Medical Student (M1) Lecturer: "Pediatric Growth and Development". Michigan Medicine, Ann Arbor, MI
02/2019-Present	Doctors of Tomorrow Preceptor: offering shadowing opportunities to students from Cass Technical High School in Detroit. Michigan Medicine, Ann Arbor, MI
03/2019-03/2019	Lecture to Division of Orthopedic Surgery: "Transgender Health". Michigan Medicine, Ann Arbor, MI

MEMBERSHIPS IN PROFESSIONAL SOCIETIES

2012 - Present	Pediatric Endocrine Society

COMMITTEE SERVICE

National

2014 - 2016	Pediatric Endocrine Society - Ethics Committee, Other, Member
2017 - present	Pediatric Endocrine Society - Special Interest Group on Gender Identity, Other, Member
2018 - present	Pediatric Endocrine Society - Program Directors Education Committee, Other, Member

Regional

2013 - 2015 Investigational Review Board - The Fenway Institute, Boston, MA, Other, Voting Member

Institutional

2017 - 2019 Department of Pediatrics at Michigan Medicine; Diversity, Equity, and Inclusion Committee, Other, Fellowship Lead

2017 - 2019 University of Michigan Transgender Research Group, Other, Director

VOLUNTEER SERVICE

2014 Camp Physician, Massachusetts, Served at a camp for youth with Type 1 Diabetes

SCHOLARLY ACTIVITIES

PRESENTATIONS

Extramural Invited Presentation Speaker

1. Grand Rounds, Shumer D, Loyola University School of Medicine, 07/2022, Chicago, Illinois

Other

1. Gender Identity, Groton School, 04/2015, Groton, MA

2. Television Appearance: Gender Identity in Youth, Channel 7 WXYZ Detroit, 04/2016, Southfield, MI

3. It Gets Better: Promoting Safe and Supportive Healthcare Environments for Sexual Minority and Gender Non-Conforming Youth, Adolescent Health Initiative: Conference on Adolescent Health, 05/2016, Ypsilanti, MI

4. Gender Identity, Humanists of Southeast Michigan, 09/2016, Farmington Hills, MI

5. Gender Identity, Pine Rest Christian Mental Health Services, 10/2016, Grand Rapids, MI

6. Pediatric Grand Rounds - Hormonal Management of Transgender Youth, Beaumont Children's Hospital, 11/2016, Royal Oak, MI

7. Transgender Youth: A Field in Transition, Temple Beth Emeth, 11/2016, Ann Arbor, MI

8. Transgender Youth: A Field in Transition, Washtenaw County Medical Society, 11/2016, Ann Arbor, MI

9. Pediatric Grand Rounds: Transgender Youth - A Field in Transition, St. John Hospital, 02/2017, Detroit, MI

10. Transgender Medicine, Veterans Administration - Ann Arbor Healthcare System, 05/2017, Ann Arbor, MI

11. Gender Identity, Hegira Programs, 05/2017, Detroit, MI

12. Care of the Transgender Adolescent, Partners in Pediatric Care, 06/2017, Traverse City, MI

13. Conference planner, host, and presenter: Transgender and Gender Non-Conforming Youth: Best Practices for Mental Health Clinicians, Educators, & School Staff; 200+ attendees from fields of mental health and education from across Michigan, Michigan Medicine, 10/2017, Ypsilanti, MI

14. Endocrinology Grand Rounds: Transgender Medicine, Wayne State University, 11/2017, Detroit, MI

15. Care of the Transgender Adolescent, St. John Hospital Conference: Transgender Patients: Providing Compassionate, Affirmative and Evidence Based Care, 11/2017, Grosse Pointe Farms, MI

16. Hormonal Care in Transgender Adolescents, Michigan State University School of Osteopathic Medicine, 11/2017, East Lansing, MI

17. Working with Transgender and Gender Non-Conforming Youth, Michigan Association of Osteopathic Family Physicians, 01/2018, Bellaire, MI

18. Community Conversations, Lake Orion, 01/2018, Lake Orion, MI

19. "I Am Jazz" Reading and Discussion, St. James Episcopal Church, 03/2019, Dexter, MI

20. Gender Identity, Michigan Organization on Adolescent Sexual Health, 10/2019, Brighton, MI; Port Huron, MI

21. Ask The Expert, Stand With Trans, 05/2020, Farmington Hills, MI (Virtual due to COVID)

22. Transgender Medicine, Michigan Association of Clinical Endocrinologists Annual Symposium, 10/2020, Grand Rapids, MI (Virtual due to COVID)

23. Transgender Youth in Primary Care, Michigan Child Care Collaborative (MC3), 10/2020, Ann Arbor, MI (Virtual due to COVID)

24. Lets Talk About Hormones, Stand With Trans, 10/2020, Farmington Hills, MI (Virtual due to COVID)

25. Gender Identity, Universalist Unitarian Church of East Liberty, 04/2021, Virtual due to COVID

26. Unconscious Bias, Ascension St. John Hospital, 05/2021, Virtual due to COVID

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2. Shumer, Spack: Medical Treatment of the Adolescent Transgender Patient. In Đorđević M; Monstrey SJ; Salgado CJ Eds. CRC Press/Taylor & Francis, (2016)

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Exhibit B

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