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CHLOE E. BROCKMAN

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF SAN JOAQUIN – STOCKTON BRANCH

CHLOE E. BROCKMAN aka CHLOE COLE, an individual

Plaintiff,

v.

KAISER FOUNDATION HOSPITALS, INC., a California Corporation, THE PERMANENTE MEDICAL GROUP, INC., a California Corporation, LISA KRISTINE TAYLOR, M.D., an individual, HOP NGUYEN LE, M.D., an individual, SUSANNE E. WATSON, PHD., an individual, LILIT ASYLYAN PSYD, an individual, and ESTER BALDWIN, LCSW, an individual, and DOES 1 through 50, inclusive,

Defendants.

Case No.: STK-CV-UMM-2023-0001612

PLAINTIFF CHLOE E. BROCKMAN'S MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES

Hearing
Department: 11B
Date:
Time:

Assigned for All Purposes to
Hon. Robert T. Waters

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I. INTRODUCTION

Plaintiff Chloe E. Brockman, aka Chloe Cole ("Chloe"), sought care from Defendants through the transgender clinic in Oakland, California, more accurately the "Gender-Disfigurement-Clinic." Defendants allowed Chloe, a 12–15-year-old girl with a complex history of unresolved mental health issues, to receive puberty blockers, testosterone, and a double mastectomy ("Gender Deforming Interventions" or "GDI"). Defendants preyed upon Chloe's delicate mental state, wrongfully validating her pre-conceived, immature notions developed through social media exposure that she was a boy and needed Gender Deforming Interventions to resolve her mental health struggles. Defendants falsely advised Chloe's parents that she was at serious risk of suicide if she did not proceed with GDI. Defendant Watson, the department head, met with Chloe a single time and that very day approved her for surgical removal of her healthy breasts.

Unsurprisingly, these Gender Disfigurement Procedures failed to resolve Chloe's complex pre-existing and concurrently presenting mental health issues. Instead, as the GDI progressed, Chloe's mental health problems only increased to include depression, suicidal ideation, and failing her classes. Chloe realized that GDI was not the ticket out of her mental health problems that Defendants promised it would be and she detransitioned. Now, in addition to having complex, unresolved mental health issues, Defendants caused Chloe to suffer medical abuse trauma. This has compounded her mental health problems causing her to suffer from Post-Traumatic Stress Disorder that will require extensive treatment throughout her adult life.

As discussed below, Defendants performed these acts with a deliberate and willful disregard for the existing medical research, which shows that GDI should never be performed on minors. This is particularly true for those in Chloe's situation with a complex mental health presentation. Additionally, Defendants induced Chloe and her parents to proceed by stating false facts regarding desistence rates, regret, suicide risk, and the claimed importance of proceeding with GDI. They also concealed critical facts that they should have disclosed relating to the many risks, including, among others, continued increased psychiatric morbidity and suicidality after GDI, the option and effectiveness of psychotherapy, the eventual need for a hysterectomy, and the problem of having a masculine appearance but atrophied female reproductive organs.

Consequently, as elaborated below, Chloe can establish a valid claim for punitive damages, and, at a minimum, a triable issue of fact as to the issue of punitive damages. Therefore, the Court should grant the Motion and allow Chloe to plead punitive damages in this case.

II. FACTUAL BACKGROUND

As a child, Chloe suffered from years of social anxiety, school and social behavioral problems and depression. She was diagnosed with Disruptive Behavior Disorder, body dysmorphia, a cleft palate, a likely eating disorder, and learning disabilities including diagnosed ADHD. (*See* Brockman ¶ 5; Levine ¶ 8(a)-(f); Crosby ¶ 5, Ex 2, p. 3-11, 17-19; Jocelyn ¶ 4-5; Szajnberg ¶ 5, Ex. 2 p. 3-12.) Some examples of her behavioral issues include throwing objects at other students, crying, screaming, yelling, and running outside of the classroom. (*See* Brockman ¶ 5; Crosby ¶ 5, Ex. 2, p. 4; Jocelyn ¶ 5.) In 2nd and 3rd grade, Chloe's desk had to be moved outside so that she could work alone. (*Ibid*.)

Around age 9, Chloe began struggling more with her female image. (*See* Brockman ¶ 6-9; Crosby ¶ 5, Ex. 2 p.9-10; Dea ¶ 5, Ex. 2 p. 8-9; Szajnberg ¶ 5, Ex. 2 p.3-4,16, 24.) Because of internet, television, social media, and pornography exposure, Chloe believed she needed to be voluptuous to be attractive. (*Ibid*.) She believed that she was not voluptuous and could never be the ideal female that she envisioned. (*Ibid*.) Also, she was exposed to many negative ideas about being female and had an undue concern of being abused or raped. (*See* Brockman ¶ 7.) She struggled with female friendships and, initially, had a better experience of male friendships, but eventually experienced bullying from males. (*See* Brockman ¶ 9.)

Chloe's mental health issues continued, and she turned to social media for answers. (*See* Brockman ¶ 9-10; Crosby ¶ 5, Ex 2 p. 19; Dea ¶ 5, Ex. 2, p. 3, 9.) Starting at around age 10, she spent many hours per day for about two years researching her feelings, including heavy exposure to LGBT social media influencers. (*Ibid*.) She gradually abandoned her idea of trying to become a voluptuous female, and decided she should try to become a boy. (*See* Brockman ¶ 11; Dea ¶ 5, Ex. 2, p.8-9.) Consequently, in May 2017, at 12 years old, she "came out" to her parents as transgender. (*See* Brockman ¶ 13.) Chloe's parents were unsure of what to do and sought medical assistance from Defendants. (*See* Jocelyn ¶ 6.) Defendants immediately affirmed Chloe's

misguided and self-diagnosed transgender identity. (*See* Brockman ¶ 14, 17, 24, 27; Jocelyn ¶ 6-8, 10, 14-15; Dea ¶ 5, Ex. 2 p. 3, 8-9.)

In August and November 2017, Defendant Lilit Asulyan, a psychological assistant without proper gender specialization, rubber-stamped Chloe's self-diagnosed gender dysphoria. (*See* Brockman ¶ 17; Dea ¶ 5, Ex. 2 p. 3, 8-10; Crosby ¶ 5, Ex. 2, p. 19-20-21.) Ms. Asulyan asserted that Chloe was definitely transgender and that puberty blockers and hormones were necessary to resolve Chloe's mental health symptoms. (*See* Brockman ¶ 17; Jocelyn ¶ 8.) She further represented that transgender individuals are at a high risk for suicide, and that Chloe needed to undergo Gender Deforming Interventions to avert this risk. (*See* Jocelyn ¶ 8; Szajnberg ¶ 5, Ex. 2 p.18.) Defendant Ester Baldwin then blindly further rubber stamped that self-diagnosis by reviewing and approving Ms. Asulyan's medical notes. (*See* Crosby ¶ 5, Ex. 2, p. 21.) Ms. Asulyan referred Chloe to an endocrinologist for puberty blockers and testosterone evaluation. (*See* Brockman ¶ 17; Jocelyn ¶ 8; Crosby ¶ 5, Ex. 2, p. 21.) Chloe consulted with an endocrinologist who would not prescribe testosterone due to her age. (*See* Brockman ¶ 18; Jocelyn ¶ 9; Crosby ¶ Ex. 2, p.21-22) Ms. Asulyan insisted puberty blockers and testosterone were necessary and found another provider willing to prescribe them. (*See* Brockman ¶ 19; Jocelyn ¶ 9.) Without question, Dr. Taylor immediately started Chloe on puberty blockers and then on testosterone. (*See* Brockman ¶ 19; Jocelyn ¶ 10; Szajnberg ¶ 5, Ex. 2 p.18.)

After Chloe began taking Lupron Depot and testosterone, her mental health problems, behavioral problems, school struggles, and related issues continued. (*See* Brockman ¶ 22; Jocelyn ¶ 11; Szajnberg ¶ 5, Ex. 2 p. 18-21, 23-25, 27.) Several months into this so-called "treatment," Chloe was sexually assaulted in the classroom in public, which deeply traumatized her. (*See* Brockman ¶ 22; Crosby ¶ 5, Ex. 2 p. 7; Szajnberg ¶ 5, Ex. 2 p. 17.) Chloe had been daily using a chest binder, which caused her great discomfort and gradually deformed her young breasts. (*See* Brockman ¶ 23.) Chloe began to view her breasts as disgusting and thought she could never be attractive with them on her body. (*Ibid*.) Consequently, she sought a double mastectomy. (*See* Brockman ¶ 22-24.)

At age 14, Chloe was referred to the "Gender-Disfigurement-Clinic" in Oakland, California

and had an approximately two-hour consultation with the multi-Specialty Team. (*See* Jocelyn ¶ 12-13; Brockman ¶ 26.) As part of this consultation, Chloe and her parents met with Defendant Susan E. Watson who approved Chloe for a double mastectomy on the spot without a single follow-up appointment. (*See* Brockman ¶ 26-27; Jocelyn ¶ 14; Dea ¶ 5, Ex. 2 p.5, 13; Crosby ¶ 5, Ex. 2 p. 22-23; Szajnberg ¶ 5, Ex. 2 p. 5). Dr. Watson introduced herself as the head of the department, represented that Chloe was definitely transgender, and that Chloe needed this "treatment" for her mental health issues. (*Ibid*.) When Chloe's father expressed concern with proceeding, a member of the MST team shut him down citing allegedly high suicide rates for transgender individuals and asserting that Chloe was at a high risk for suicide if she did not go through with the surgery. (*See* Jocelyn ¶ 13; Szanjberg ¶ 5, Ex. 2 p. 14.) The MST team also falsely represented that desistence was very rare. (*See* Jocelyn ¶ 13-14.) This was the first and only time Chloe saw Dr. Watson prior to the mastectomy. (*Ibid*.)

Also, as a part of this same two-hour consultation, Chloe and her parents met with Defendant Hop Nguyen Le, a plastic surgeon, who also approved Chloe for a double mastectomy on the spot and currently performed a surgery consultation. (*See* Brockman ¶ 26; Jocelyn ¶ 15.) Prior to her surgery, Chloe had no further contact with Dr. Watson or Dr. Le except for a final pre-op video consultation with Dr. Le nearly a year later. (*See* Brockman ¶ 26; Jocelyn ¶ 14, 17-18.) After this consultation, Chloe's mental health issues continued and got worse. She had depression, anxiety, problems with social interaction, and for the first-time suicidal ideation. (*See* Brockman ¶ 28; Jocelyn ¶ 17; Dea ¶ 5, Ex. 2 p.5-6; Crosby ¶ 5, Ex. 2 p. 22-24; Szajnberg ¶ 5, Ex. 2 p. 3-12, 16-24.) Nevertheless, about a year later on June 4, 2020, Dr. Le mechanically proceeded with removing both of Chloe's healthy breasts at age 15 and permanently disfiguring her. (*See* Brockman ¶ 30.)

Chloe's mental health continued to decline. (*See* Brockman ¶ 31-32; Jocelyn ¶ 19; Dea ¶ 5, Ex. 2 p.6; Crosby ¶ 5, Ex. 2 p. 10-11; Szajnberg ¶ 5, Ex. 2 p. 3-12, 16-25.) Among other problems, she had aggravated behavioral problems such as getting in fights and hiding in locker rooms, social anxiety, lack of friends, learning problems including failing out of school, bouts of depression accompanied by suicidal ideation, and other related issues. (*Ibid*.) Chloe was shocked and

traumatized after her surgery as she was unprepared to see the large wounds on her chest. (*See* Brockman ¶ 31; Joceyln ¶ 18, Ex. B, NOL Ex. 5.) Chloe's trauma intensified when her grafts turned black because they separated from her chest tissue and then reattached, causing the outer layer of tissue to die. (*Ibid*.) Several months later, Chloe realized these Gender Deforming Interventions were not helping her problems and she detransitioned. (*See* Brockman ¶ 33, 47; Dea ¶ 5, Ex. 2 p. 7-8; Szajnberg ¶ 5, Ex. 2 p. 20-22.) Chloe had a couple of visits with Dr. Watson regarding her detransition, who gave Chloe some woefully belated advice: "I let 'him' know it will be important for him to take steps to change the things he can, but to find a way to accept the things he cannot change." (*Ibid*.) In other words, you need to learn to live with this ill-informed and disfiguring sex-change experiment we performed on you.

Defendants' efforts to turn a teenage girl into a boy left Chloe with serious and permanent side-effects. Chloe's declaration contains a more complete statement of her extensive pain and suffering resulting from this experimental treatment. (*See* Brockman ¶ 34-46; Crosby ¶ 5, Ex. 2 p. 24-25, 27.) Additionally, the Defendants have caused Chloe to suffer severe medical trauma as a consequence of participating in this reckless, failed medical experiment. (*See* Szajnberg ¶ 5, Ex. 2 p. 13-34.) As a result, she suffers from Post-Traumatic Stress Disorder and will require extensive, regular, mental health treatment throughout her adult life. (*See* Szajnberg ¶ 5, Ex. 2 p. 29-38.)

III. LEGAL STANDARDS

Chloe must obtain leave of court before seeking punitive damages by substantiating a legally sufficient punitive damages claim. (*See* Cal. Code Civ. Proc. § 425.13(a); *College Hospital Inc. v. Superior Court*, 8 Cal.4th 704 (1994) 34 Cal.Rptr.2d 898, 906-908 ("*College*").). This standard operates like a reverse demurrer or summary judgment motion. (*Ibid.*) The court is not permitted to weigh evidence under this standard and should grant the motion if the supporting evidence reveals the existence of a triable issue of fact regarding Chloe's claim for punitive damages. (*Ibid*.) To recover punitive damages a Plaintiff must prove oppression, fraud, or malice by clear and convincing evidence, defined as follows:

> (1) "Malice" means conduct which is intended by the defendant to cause injury to the plaintiff or despicable conduct which is carried on by the defendant with a willful and conscious disregard of the rights or safety of others.

(2) "Oppression" means despicable conduct that subjects a person to cruel and unjust hardship in conscious disregard of that person's rights.

(3) "Fraud" means an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury.

(*See* Cal. Code Civ. Proc. § 3294(a), (c).) Conduct is despicable when it is "'base,' 'vile,' or 'contemptible.'" (*Pfeifer v. John Crane, Inc.* (2013) 220 Cal.App.4th 1270, 1299 (citation omitted).)

A corporate employer is liable for punitive damages if an officer, director, or managing agent, with policy influencing authority, has engaged in malicious, oppressive, or fraudulent conduct, or if it has ratified or authorized the malicious, oppressive, or fraudulent conduct by a non-managerial employee. (*See* Cal. Code Civ. Proc. § 3294(b); *White v. Ultramar, Inc.* (1999) 21 Cal.4th 563; 572 et seq.) Additionally, evidence of recidivism by a corporate defendant supports a claim for punitive damages. (*See Johnson v. Ford Motor Co.* (2005) 35 Cal.4th 1191, 1204.)

In the medical malpractice context, punitive damages are adequately supported by evidence that a physician provided misleading information to, or concealed relevant information, from a patient regarding the treatment provided. For example, in *Divino Plastic Surgery, Inc. v. Superior Ct.* (2022) 78 Cal.App.5th 972, 977, 985, *as modified on denial of reh'g* (May 19, 2022), the surgeon allegedly represented that a licensed anesthesiologist would be present at the *breast augmentation surgery* to induce the patient's consent to surgery. Even though performing surgery without a licensed anesthesiologist was legally permissible, not having a licensed anesthesiologist at the surgery would render the pre-surgery representation false. If the allegation of falsity were believed, it could support a claim of punitive damages.

As an additional example, in *Baker v. Sadick* (1984) 162 Cal.App.3d 618, 625, the patient obtained a punitive damage award on the basis that the surgeon performed an *unnecessary breast reduction surgery* and induced the patient's consent fraudulently. The court confirmed the arbitration award noting that fraudulently inducing consent to an unnecessary treatment asserts a willful wrong that supports punitive damages.

The case of *Nelson v. Gaunt* (1981) 125 Cal.App.3d 623, 635, is also relevant, in holding

that providing a *cosmetic breast surgery* patient "with false and misleading information and knowingly conceal[ing] information that was material to the cause of [her] injuries" is fraudulent conduct). The case of *Valbona v. Springer* (1996) 43 Cal.App.4th 1525, 1531, also upheld a punitive damages award where the physician falsely represented that the application for a cellulite removal process was pending before the FDA. The case of *Hahn v. Mirda* (2007) 147 Cal.App.4th 740, did not involve punitive damages, but held that the Plaintiff properly asserted a claim for fraudulent concealment based on Defendant physician's failure to disclose material facts leading to an unnecessary mastectomy. The present case of a vulnerable 15-year-old girl having her healthy breasts removed presents a much more compelling case for punitive damages than the aforementioned cases.

IV. ARGUMENT

Chloe can proffer sufficient evidence that, if believed, is adequate to support a claim for punitive damages. Here, Defendants engaged in oppressive, fraudulent, and malicious conduct when they: (1) willfully and deliberately deviated from the standard of care deliberately disfiguring a vulnerable, young, and emotionally distraught minor female causing her permanent damage; and (2) fraudulently and oppressively induced Chloe and her parents' consent to the disfigurement by, among other things, falsely claiming that Chloe presented a significant suicide risk if she did not participate in this experiment.

C. Defendants' Willfully and Deliberately Breached the Standard of Care.

a. Poor Quality Medical Research Should Prevent Gender Deforming Interventions on Minors.

The medical research regarding GDI in minors is of such a low quality that conclusions regarding the long-term treatment outcomes are unknown at best, and the use of GDI to "treat" minors amounts to an abusive social and medical experiment. (*See* Levine ¶ 4, Ex. 2, p. 23-27, 37-44.) One of the foremost objective medical literature reviews in the U.S. is performed by the Hayes Corporation ("Hayes"), which gives adolescent hormone treatment the lowest "D2" rating. (*See* Laidlaw ¶ 248; Perrotti ¶ 14.) Hayes analyzed the research twice in 2014 and 2018, concluding in both reports that research findings in this area were "too sparse" and "too limited" to

even *suggest* conclusions and that there is "insufficient published evidence to assess the safety and/or impact on health outcomes or patient management." (Ibid.) Finland, Sweden, England, Florida's Boards of Medicine, and many others, have all conducted systematic reviews concluding that GDI should not be permitted for minors because the risk/benefit ratio of GDI for youth ranges from unknown to unfavorable. (*See* Levine ¶ 6(d); Perrotti ¶ 14; Laidlaw ¶ 258-265, 286-289.) The U.S. Centers of Medicare and Medicaid Services' criteria for treatment of gender dysphoria with cross-sex hormone therapy and surgical treatment both include the requirement that the patient be "at least 18 years of age" and have found that the evidence is inconclusive. (*See* Levine ¶ 6(b); Perrotti ¶ 15; Laidlaw ¶ 281.) Kaiser's own standards for the Pacific Northwest Region require that a patient be at least 18 years of age to receive a mastectomy and, in exceptional circumstances, allows a patient to receive a mastectomy as young as 16, but no younger.[1]

b. **Increased Mental Health and Suicide Risk and High Minor Desistence Rates Should Prevent Using Gender Deforming Interventions for Minors.**

One high quality large 40-year population-based studies from Sweden found that individuals who undergo sex-reassignment treatment are at a substantially increased risk of mental health co-morbidities including suicidality and completed suicide attempts compared with the general population. (*See* Laidlaw ¶ 254-265; Perrotti ¶ 13; Levine ¶ 6(m).) A Denmark study of transgender identifying individuals, not taking into consideration whether GDI had been performed, found a similar result. (*Ibid.*) Furthermore, as to minors, desistence rates in children are well studied and eleven uncontested studies show that around 80%-90% of children desist from an opposite sex gender identity upon reaching adulthood. (*See* Levine ¶ 4, Ex. 2, p. 23-27; 43-44; Perrotti ¶ 16; Laidlaw ¶ 270-272, 289.) Plaintiff's psychiatric expert, Dr. Robin Dea, former director of the Kaiser transgender clinic in Oakland, California, has stated the issue as follows:

> The scientific research clearly shows that the overwhelming majority of gender non-conforming children do not become transsexual. Between the ages of 9-11, do there exist scientific studies that show the clinicians can clearly tell the difference between those that will and those that won't become transsexual? The answer is no. To treat children with hormones and puberty blockers is to subject a majority of such children to inappropriate treatment, which is clearly unethical. The ethical stance is to offer supportive psychotherapy, clearly outlining for children and

[1] https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/health-plan-documents/coverage-information/clinical-review-gender-affirming-procedures-nw.pdf

> parents the potential outcomes, and allowing the child to mature enough to make a decision in late adolescence.

(*See* Dea ¶ 5, Ex. 2, p. 2.) Furthermore, GDI is not neutral, rather, it has a tendency to cause a child to persist, at least for a time, in a transgender identity, and there is no research demonstrating that this result creates any long-term benefit. (*See* Levine ¶ 4, Ex. 2 para. 60-69.) Though, as noted above, the Swedish study represents strong evidence demonstrating that as a demographic group, transgender individuals, who received GDI, have a much higher risk of co-morbidities and suicidality. In sum, GDI "*is an experimental procedure that has a high likelihood of changing the life path of the child, with highly unpredictable effects on mental and physical health, suicidality, and life expectancy*." *See* (Levine ¶ 4, Ex. 2 para. 69.)

c. **Gender Identity Disorder Must be Treated as a Part of a Comprehensive Mental Health Evaluation and Treatment Plan, not as an Isolated Issue, and Must Not Favor Affirming of a Cross-Gender Identity.**

The APA Handbook on Sexuality and Psychology states: "Premature labeling of gender identity should be avoided. . .This approach runs the risk of neglecting individual problems the child might be experiencing and may involve an early gender role transition that might be challenging to reverse if cross-gender feelings do not persist." (Levine ¶ 6(p).) Additionally, well established research on the plasticity of minors' cognitive functions, notes as follows:

> Brain maturation during adolescence (ages 10–24 years) could be governed by several factors…sex hormones including estrogen, progesterone, and testosterone can influence the development and maturation of the adolescent brain…Furthermore, the adolescent brain evolves its capability to organize, regulate impulses, and weigh risks and rewards; however, these changes can make adolescents highly vulnerable to risk-taking behavior…Plasticity permits adolescents to learn and adapt in order to acquire independence; however, plasticity also increases an individual's vulnerability toward making improper decisions because the brain's region-specific neurocircuitry remains under construction, thus making it difficult to think critically and rationally before making complex decisions.

(*See* Levine ¶ 6(i).). Even WPATH, a political advocacy group in this area knowingly perpetuating harmful guidelines encouraging GDI for minors, recognizes the need to assess mental health co-morbidities and treat them before performing GDI.[2] (*See* LiMandri ¶ 7, Ex. C.) Patients seeking

[2] WPATH Standard 6.3 for adolescents requires "a comprehensive biopsychosocial assessment" before receiving GDI. WPATH Standard 6.12.d for adolescents counsels that a patient's "mental health concerns that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed." WPATH, SOC 7, No. 3 requires Defendants to "[a]ssess and treat any co-existing mental health concerns (or refer to another mental

GDI as a part of a perceived gender dysphoria differ widely in their presentation and must be considered individually. (*See* Levine ¶ 4, Ex. 2 para. 54-59.) These individuals frequently have a wider history of diagnosed, or undiagnosed, psychiatric co-morbidities that require treatment. (Ibid.) It is essential for the mental health provider to spend "more than one working session" with the patient and to "spend significant time with an individual patient over multiple sessions to take a careful developmental history, before attempting to decide on a course of therapy for that individual." (Ibid.)

d. **Defendants Acted With Malice, Oppression, and Fraud By Following the "Diagnose-Yourself" Treatment Model and Allowing Political Ideology to Determine Treatment Policies.**

As a matter of institutional policy, Kaiser follows the "Platinum Rule" when treating gender identity disorders ("GID"). Under this rule, "**Someone is the gender they say they are** regardless of their transition process."[3] (*See* Brockman ¶ 14-31; Jocelyn ¶ 6-28; Dea ¶ 5, Ex. 2 p. 12-13; Wohl-Sanchez ¶ 15-50; Bourne ¶ 3, Ex. 1.) Kaiser's Training materials confirm that its policy requires mental health providers to "rely on self-identification" by the patient and follow the rule that "mental health providers are not assessing gender." (*See* LiMandri ¶ 2, Ex. 1.) Dr. Dea observed that Defendants followed this dangerous policy in Chloe's case, allowing her to self-diagnose as transgender:

> **Chloe's experience is a perfect example of what happens when social and political ideologies drive medical models of care instead of scientific evidence.** When Chloe arrived in June 2017 and said she was transgender, the appropriate medical sequence of events was assumed. There was no gender evaluation. A simple request of "Tell me the story" would have unearthed that the origin of her gender dysphoria was feelings of inadequacy about her breast size and the shape of her shoulders and hips. It would have included knowing about how she had been influenced on social media, and what her contacts there had told her. That would have led to a discussion of what she had learned that was valid and what was unreasonable pressure from people who did not know her and likely had their own political interests at heart. There was no discussion of core gender identity and how she had felt being a girl up to age 11, prior to online pressure. There was no discussion about gender role behavior and the style of a boy or girl she saw herself as. There was no discussion about her awareness of her own sexuality. Since she sees herself as androphilic, a discussion of the experience of transmen in the gay male community would have been appropriate.
>
> **Instead, the moment she said she was transgender, it was assumed that no**

health professional for treatment)" and instructs that "such concerns should be addressed as part of the overall treatment plan." WPATH SOC 7 required that Defendants conduct an "extensive exploration of psychological, family, and social issues."

[3] https://www.libsoftiktok.com/p/exclusive-whistleblower-exposes-hospital.

> **<u>further evaluation was necessary. There is no evidence that the person she saw for her first evaluation (Dr. Asulyan) had any experience in evaluating transgender children or adolescents, and her clinical notes would indicate she didn't.</u>** She simply put Chloe on a medical conveyor belt, and before the next session had already made an inquiry about an appointment for Chloe for evaluation for puberty blockers and hormones. The first time Chloe saw a true gender specialist, Dr. Watson, was for the evaluation of appropriateness for mastectomy in July 2019. Dr. Watson saw the changes Chloe had made, and that she had been living as male. Dr. Watson did not know or question that the original diagnosis was made by Chloe, not a gender specialist following a careful evaluation.

(*See* Dea ¶ 5, Ex. 2 p. 12-13 (Emphasis Added).)

As an institution, Kaiser is well aware of that there are serious risks and critical knowledge gaps in this area. In Dec. 2017, Kaiser published a study of 6456 transgender patients at Kaiser from 2006 to 2014, in which Kaiser admits as follows: "Critical knowledge gaps include the effect of HT [hormone therapy] and surgery on gender dysphoria (the feeling of distress when natal sex does not match gender identity) and other mental health issues, hematological side effects of HT and risk of cardiovascular disease, metabolic or endocrine disorders and cancer following hormonal or surgical gender affirmation." (*See* LiMandri ¶ Ex. 3.) Despite being well aware of and publishing a study identifying these critical risks and knowledge gaps, Kaiser follows a policy of doing whatever the patient asks in this area without disclosing any of these risks.

Here, the Defendants perpetuated willful and deliberate deviations from the standard of care by instituting and following Gender Deforming Intervention policies that ignore the lack of proper medical research and the experimental nature of this treatment. These policies perpetuate self-diagnosis by patients who have no psychological training, who are very likely to be suffering from an impaired mental state, and who are unable to objectively assess their own mental health condition. As to minors, these problems are compounded by the tendencies toward desistence, and are further exacerbated by a psychological and neurological state that is only partially developed and immature. Allowing minors to self-diagnose and determine treatment will necessarily cause serious harm to patients such as Chloe. Consequently, these policies as followed in Chloe's case, establish a triable issue of fact that Defendants engaged in malice, oppression, and fraud, justifying the pleading of punitive damages.

/ / /

e. **Defendants Committed Malice, Oppression, and Fraud by Deliberately Performing a High-Risk Sex Change Experiment on an Emotionally Distraught, Sexually Abused, Minor Female with a Long History of Unresolved Mental Health Issues.**

In Chloe's case, Defendants deliberately breached the standard of care by rubber-stamping Chloe's self-diagnosed transgenderism and sending her down a pre-determined damaging path of irreversible hormones and surgery. Chloe was a young minor female with no understanding of sexuality, while struggling with increased negative emotions with the onset of puberty, and negative body image issues. (*See* Brockman ¶ 6-11, 21; Crosby ¶ 5, Ex. 2 p. 9-10; Dea ¶ 5, Ex. 2 p. 8-9; Szajnberg ¶ Ex. 2, p. p. 3-4, 16, 24.) She also had a complex and conflicting history of unresolved mental health issues. (*See* Brockman ¶ 5-11, 15-16, 22-23, 25, 28, 31-32; Crosby ¶ 5, Ex. 2 p. 9-34; Dea ¶ 5, Ex. 2 p. 3-13; Levine ¶ 8; Szajnberg ¶ 2, p.3-12.) She self-diagnosed as transgender around age 12 after spending hours per day for multiple years on social media viewing content by transgender social media influencers. (*See* Brockman ¶ 10-14; Crosby ¶ 5, Ex. 2 p. 10; Dea ¶ 5, Ex. 2 p. 8-9.) Chloe's primary motivations for her self-diagnosed transgenderism, and her misguided belief that she should become a boy, stemmed from feeling unsafe as a woman (*i.e.,* concern for being sexually abused) and from feeling like she could never be the type of physically attractive woman she wanted to be with large breasts. (*See* Brockman ¶ 6-11; Crosby ¶ 5, Ex. 2 p.9-10; Dea ¶ 5, Ex. 2 p. 8-9.) These motivations are completely incompatible with Chloe's self-diagnosed transgenderism. (*See* Dea ¶ 5, Ex. 2 p. 5, 9.)

Dr. Robin Dea discusses Defendants' extreme, surprising, and willful departure from the standard of care as follows:

> While Chloe's experience was complex, as most cases are with children with multiple diagnoses, two major issues stand out for Chloe. The first is that the medical and mental health records show that **there was not an evaluation for gender dysphoria that any experienced clinician would recognize as such. Essentially Chloe made her own diagnosis after two years of secretly interacting online at night with gender activists, who convinced her she was transgender.** This was between ages 11 and 13. In answer to questions posed to Chloe about the beginnings of her gender dysphoria, she reported "I was not aware of any dysphoric feelings prior to using social media and learning about sexuality, gender identity and transitioning from it. I wanted to have a full figure and look womanly but at the same time I had mixed but mostly negative feelings about the attention I got from family, peers, etc when I started puberty at 9." In answer to another question, she stated "from a young age I had a desire to at least have big breasts. I attribute this to early television, internet, social media, and porn exposure

but also what I would overhear from conversations between my older teenage relatives including my sisters. Early in childhood, I picked up on the idea that having big boobs is a good, desirable, ideal trait in women, and that small breasts are forgettable and not desirable."

One needs to keep in mind that these feelings were being formulated by an 11 year-old, and as such are not surprising. **Experienced clinicians however are aware that female to male transsexuals do not have fantasies about having big breasts.** In fact, as breasts start to develop, they find the experience abhorrent. Chloe was feeling inadequate because she didn't realize that the size of one's breasts at 12-13 years old is not indicative of adult size. Her feelings of inadequacy were mistaken by her, under the influence of social media, for being male as a fallback position. The sequence of thinking is understandable in a girl her age, but not indicative of gender dysphoria. A thorough evaluation by an experienced clinician would have detected:

1. No cross-gender feelings until age 11
2. Those feelings seem to have been generated by interacting with others online
3. Her feelings were fears of inadequacy as a female, not feelings of being male or identifying with having a male body.

Instead, her diagnosis was made by her, and rubber stamped by every clinician with whom she came in contact.

(Dea ¶ 5, Ex. 2 p. 8-9 (Emphasis Added).)

Defendants executed a pre-determined, rubber-stamped, decision to perform an ill-conceived sex change experiment on a vulnerable, emotionally distraught 13-year-old girl, and allowed Chloe's naïve, transgender self-diagnosis to dictate her treatment. The institutional Defendants ratified, consented to, and perpetuated these acts by having a policy to promote and support Gender Deforming Interventions for minors that gives them whatever is requested irrespective of the harm caused. (Brockman ¶ 14-30; Jocelyn ¶ 6-28; Dea ¶ 5, Ex. 2 p. 12-13; Wohl-Sanchez ¶ 15-50; Bourne ¶ 3, Ex. 1; LiMandri ¶ 2, Ex. 2.) Defendant's training materials note that top surgery "often is a patient's first ever surgery" and the "most common gender-affirming surgery performed at KP on patients under 18." (LiMandri ¶ 2, Ex. 2.) As a matter of institutional policy, Defendants consciously disregarded Chloe's wellbeing and willfully deviated from the standard of care, while deliberately proceeding down a path with a certain likelihood of causing Chloe severe harm. Consequently, this motion should be granted.

D. Defendants Engaged in Fraud, Malice, and Oppression by Making Fraudulent Statements and Deliberately Concealing Material Information.

"Because a patient relies upon her physician's greater medical knowledge when seeking

medical treatment, the physician has a fiduciary-like duty to obtain his patient's informed consent regarding which course of treatment to pursue." (*Flores v. Liu* (2021) 60 Cal.App.5th 278, 292 (citation omitted).) "A doctor's obligation to obtain a patient's informed consent to medical treatment includes 'a duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each.'" (*Schiff v. Prados* (2001) 92 Cal.App.4th 692, 694 (quoting *Cobbs v. Grant* (1972) 8 Cal.3d 229, 243).) Here, Defendants also engaged in fraud, malice, and oppression by making false statements and concealing important information from Chloe and her parents regarding GDI.

Fraudulent Statements Regarding Desistence: Among other things, Ms. Asulyan misrepresented that desistence is very rare and happens in less than 1% of cases of gender dysphoria. Dr. Watson made a similar misrepresentation that desistance and regret are very rare. These statements are false. As noted above, desistence is very common, and the vast majority of children desist from a transgender identity if simply left alone. (*See* Levine ¶ 4, Ex. 2, p. 23-27; 43-44; Perrotti ¶ 16; Laidlaw ¶ 270-272, 289; Dea ¶ 5, Ex. 2 p. 2.)

Fraudulent Statements Regarding Suicide and the Necessity of Gender Deforming Interventions: Ms. Asulyan and Dr. Watson misrepresented the suicide risk, the necessity of GDI to avert that risk, and the necessity of GDI to resolve Chloe's mental health problems. These were all false statements. Chloe was not suicidal until after she began GDI, and there are no studies demonstrating that "affirmation of children (or anyone else) reduces suicide, prevents suicidal ideation, or improves long-term outcomes, especially as compared to either a "watchful waiting" or a psychotherapeutic model of response…" (*See* Levine ¶ 4, Ex. 2 p.34-36, ¶ 9(f); Brockman ¶ 28, 31-32; Jocelyn ¶ 17, 19; Dea ¶ 5, Ex. 2 p.5-6; Crosby ¶ 5, Ex. 2 p. 10-11, 22-24.)

Concealment: Collectively, Defendants concealed from Chloe and her parents among other things, the following information: (1) the high rates of desistence for minors and the significant risk of regret; (2) the limited, low-quality medical research and experimental nature of GDI; (3) the high risk of continued increased psychiatric morbidity and suicidality even after GDI; (4) the option and effectiveness of psychotherapy in lieu of GDI; (5) the damaging effect of testosterone on female reproductive organs and the eventual need for a complete hysterectomy; (6) the effects

on intimacy and relationships of appearing more masculine but having atrophied female reproductive organs; (7) the next steps of "bottom surgery" and the related high complication rates and lifelong medicalization; and (8) the extensive detrimental physical health risks of testosterone on biological females. (*See* Jocelyn ¶ 22-28; Brockman ¶ 21, 27.)

The existence of fraud and concealment by the defendants pertaining to these issues is also a matter of institutional policy. Dr. Susan Watson was the former director and set policy for the "Gender-Disfigurement-Clinic" and she personally engaged in these affirmative misrepresentations and concealments. Additionally, the false misrepresentations and concealments were not unique to Chloe's case, which evidences an underlying institutional policy to coercively induce consent to Gender Deforming Interventions by providing false information and concealing true information. (*See* Brockman ¶ 14-30; Jocelyn ¶ 6-28; Dea ¶ 5, Ex. 2 p. 12-13; Wohl-Sanchez ¶ 15-50; Bourne ¶ 3, Ex. 1; LiMandri ¶ 2-3; NOL, Ex. 2-3; Lovdahl Decl. ¶ 2-25.)

Defendants' coercion, concealment, misrepresentations, and manipulation are appalling, base, vile, and contemptible, and represent an egregious, deliberate, and willful breach of the standard of care, causing severe damage to Chloe and constituting fraud, malice, and oppression.

V. CONCLUSION

Based on the foregoing arguments and authorities, Plaintiff hereby requests that the Court grant this Motion and allow her to amend her complaint so that she may seek an award of punitive damages at trial against each of the Defendants in this action.

Dated: April 18, 2024

LiMANDRI & JONNA, LLP
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COURT OF THE STATE OF CALIFORNIA SAN JOAQUIN SUPERIOR COURT – STOCKTON BRANCH		FOR COURT USE ONLY
TITLE OF CASE (Abbreviated) **Chloe E. Brockman v. Kaiser Foundation Hospitals, Inc., et al.**		
ATTORNEY(S) NAME AND ADDRESS Charles S. LiMandri, Esq; Paul M. Jonna, Esq. Robert E. Weisenburger, Esq. LiMANDRI & JONNA LLP P.O. Box 9120 Rancho Santa Fe, California 92067 Tele: (858) 759-9930; Fax: (858) 759-9938		
ATTORNEY(S) FOR: Plaintiff Chloe E. Brockman	Dept. 11B	CASE NO.: STK-CV-UMM-2023-0001612

PROOF OF SERVICE

I, Rebecca M. Oakley, declare that: I am over the age of 18 years and not a party to the action; I am employed in, or am a resident of the County of San Diego, California, and my business address is P.O. Box 9120, Rancho Santa Fe, CA 92067, Telephone number (858) 759-9930; Facsimile number (858) 759-9938. I further declare that I served the following document(s) on the parties in this action:

Motion for Leave to Amend

1. **PLAINTIFF CHLOE E. BROCKMAN'S NOTICE OF MOTION AND MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;**
2. **PLAINTIFF CHLOE E. BROCKMAN'S MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;**
3. **PLAINTIFF CHLOE E. BROCKMAN'S NOTICE OF LODGMENT OF CONFIDENTIALLY MARKED DOCUMENTS IN SUPPORT OF MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;**
4. **DECLARATION OF CHLOE E. BROCKMAN;**
5. **DECLARATION OF CHARLES S. LIMANDRI IN SUPPORT OF PLAINTIFF CHLOE E. BROCKMAN'S MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;**
6. **DECLARATION OF JOCELYN T. BROCKMAN;**
7. **DECLARATION OF ROBIN A. DEA, M.D.;**
8. **DECLARATION OF NATHAN SZAJNBERG, M.D.;**
9. **DECLARATION OF MICHAEL LAIDLAW, M.D.;**
10. **DECLARATION OF JOHN PERROTTI, M.D.;**
11. **DECLARATION OF STEPHEN B. LEVINE, M.D.;**
12. **DECLARATION OF TIM CROSBY, LMFT;**
13. **DECLARATION OF KAYLA LOVDAHL;**
14. **DECLARATION OF ELISABETH "BETH" BOURNE;**
15. **DECLARATION OF LAUREN WOHL-SANCHEZ;** and
16. **[Proposed] ORDER In SUPPORT OF PLAINTIFF CHLOE E. BROCKMAN'S MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES.**

Motion to Seal

1. **PLAINTIFF CHLOE E. BROCKMAN'S NOTICE OF MOTION AND MOTION TO SEAL DOCUMENTS LODGED IN SUPPORT OF MOTION FOR LEAVE TO AMEND**

COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;

2. **PLAINTIFF CHLOE E. BROCKMAN'S MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION TO SEAL DOCUMENTS LODGED IN SUPPORT OF MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;** and
3. **[Proposed] ORDER In SUPPORT OF PLAINTIFF CHLOE E. BROCKMAN'S MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION TO SEAL DOCUMENTS LODGED IN SUPPORT OF MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES**

by one or more of the following methods of service to:

****SEE ATTACHED SERVICE LIST**

_____ (**BY U.S. MAIL**) I caused such document(s) to be sealed in envelopes, and with the correct postage thereon fully prepaid, either deposited in the United States Postal Service or placed for collection and mailing following ordinary business practices.

__X__ **(BY E-MAIL/ELECTRONIC MAIL)** I caused a copy of the foregoing document(s) to be sent to the persons at the e-mail addresses listed above, this date via internet/electronic mail.

__X__ (**BY ELECTRONIC FILING/SERVICE)** I caused such document(s) to be Electronically Filed and/or Service through OneLegal.

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

Executed on April 18, 2024

Rebecca M. Oakley

COURT OF THE STATE OF CALIFORNIA
SAN JOAQUIN SUPERIOR COURT – STOCKTON BRANCH

Chloe E. Brockman v. Kaiser Foundation Hospitals, Inc., et al.
CASE NO.: STK-CV-UMM-2023-0001612

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