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July 23rd, 2018

To: Dr. Danny Jacobs and Amy Penkin, LCSW, Sally Rogers, M.A., F.A.C.M.P.E., Dr. Kenneth Azarow

We are a group of former and current patients of the Transgender Health Program (THP) at OHSU, medical providers who work with Transgender patients and clinicians who write surgical referrals. We have concerns about multiple levels of care and program development within the current incarnation of the THP at OHSU. We are writing to inform you of these concerns, and to make specific recommendations for the THP and OHSU going forward. We believe strongly that nothing can be about us as a community, without our involvement in all stages of the process.

We will begin with a brief overview of recommended changes to the THP, follow with stories from patients that illustrate the issues, and end with a detailed discussion of our recommendations.

Recommendations in Brief

Enhanced Surgical Training. We desire to see policy implemented to increase the minimum surgical training requirements for the THP surgeons, as mentioned in the WPATH Standards of Care for Transsexual, Transgender and Gender-Nonconforming People (SOC).

Data Collection, Evaluation & Independent Review. We are seeking the implementation of a comprehensive data collection tool, independent evaluation of that data and finally, patient and medical community sharing of that scrubbed data.

Staff Expansion. We would like to see a newly-hired, non-surgical medical director. The burden of the THP in its entirety can not fall solely onto the shoulders of a physician.

Formal Grievance Procedure. We desire to see the creation of formal policy and procedure for grievance and escalation at the THP at OHSU. A written plan, separate from that of the hospital, that allows for resolution to grievances from patients.

Community Advisory Board (CAB). The addition of a CAB is necessary. The incorporation of stakeholder voices in the further development and growth of the THP at OHSU could have brought some or all of these issues to light previously, or prevented them from happening.

Trauma-informed System of Care. A common thread that wove through most of our experience, in all areas of the program, was a lack of empathy toward us as patients. Systemic failures exist within the program that have lead us to become more medically traumatized, rather than to healing as a result of surgical intervention.

Our Stories

Patient 1

I had surgery with Dr. Dugi almost a year ago. I had many issues with the process of scheduling, with my actual surgery and with after-care. The most significant issue being what appears to be an unfinished urethroplasty, leaving a hole where my urethra should be, large enough to place a thumb into. Despite several conversations with Dr. Dugi before my surgery about using skin grafts from my hips to create vaginal lining, as the scrotum still was hair-producing, scrotal tissue was still used internally. I subsequently have internal hair growth. My clitoris is exceptionally large, and I have substantial holes on either side that never healed shut. My general aesthetic is not anatomical. I have what is believed to be permanent nerve damage in my right ankle, from the surgical positioning of my body during my 12 hour surgery. I experience numbness and tingling from my toes to half way up my shin, which has not responded to chiropractic techniques to relieve compression on the nerve. I am now scheduled for a revision surgery with another doctor, to redo around 50% of the original surgery. OHSU has no formal escalation process, and when I complained about these issues, I was sent to their risk management team. I was ultimately told that my only option for resolution was to file a lawsuit.

Patient 2

I had surgery with Dr. Dugi a couple years ago. My time in the surgery theater was significantly longer than normal, likely leading to complications and extended healing time I experienced later. During in-hospital recovery, it seemed as if staff was ill-prepared to deal with post-surgery trauma. At one point I had to beg for one extra day of in-hospital stay because they seemed to be in such a hurry to discharge me well before I felt confident in my ability to take care of myself. Follow up care was difficult to acquire outside of scheduled post-op visits; I didn't get very timely responses to email if at all and phone calls were typically answered by a desk nurse that had little to no relevant experience or ability to provide advice. Found myself in several situations where tearing and bleeding occurred that seemed unusual and had no way to confirm one way or the other for sure. During the scheduled visits, I had to specifically ask Dugi to check on things like whether there was internal hair growth (thankfully there wasn't). I don't really have complaints aesthetically except that both sides of my labia have a strange skin tag, almost as if both come to a small triangular point, which I can only assume is some sort of stitching anomaly. Sensation is good in the sense that I have sensation, but I've had extreme difficulty achieving orgasm to the extent that I no longer bother masturbating. I've had maybe ten orgasms in nearly two years, and rarely via sex. This lack of stimulation has led to me having near constant sexual dreams like I'm a teenager again, which is distracting and frustrating.

Patient 3

I had gender confirmation surgery with Dr. Dugi a year ago this July 29th. Within days of my surgery, I developed an abscess behind the area of my upper pubic bone and clitoris. I reported this to Dr Dugi, and was treated with multiple antibiotic regimens. Over the course of the

treatment, the abscess was lanced by Dr. Witten, and the wound was left open for packing and drainage. This has long since healed, and am left with a scar for 'bragging rights'. As part of the GCS crafting process, I was left with a lump of flesh interposed directly below my clitoris, and directly above the location of my urethra. It appears to serve no other purpose than to block and disperse my urine stream. If the stream is no more than a dribble, no problem. Should I have more pressure behind my bladder than what I can feel, this lump of flesh makes these higher pressured urine streams spray all over the underside of my legs, buttocks, and the interior of whatever waterworks upon which I happen to be perched at the moment. I do not possess a neo-vagina, due to the surgery and radiation I received for treating my prostate cancer. I am more than mildly incontinent as a result of both surgeries. Stimulus and response of my clitoris is marginal at best, and totally depressing at worst. Ninety per cent of the time that I urinate, I have an orgasm. Not sure how this came about, but the novelty has certainly paled significantly. The cosmetic appearance/value of the GCS I received isn't all that great. My clitoris looks like a poor after thought. And what labial lip-works I have, look like they're attached to my legs on the ventral side and flapping in the wind on the dorsal side.

Patient 4

I had phalloplasty surgery with Drs. Dugi and Berli almost two years ago, had numerous complications, including lingering bad side effects from anesthesia and surgical trauma. Both surgeons misrepresented their expertise, experience, and readiness. My first, of three surgeries was incomplete, and took 17 hours, more than twice as long as it should. My penis is half as long as it's supposed to be due to poor surgical technique, and cutting the flap shorter than agreed. My SCIP flap urethra scar is 44 cm long, twice as long as it should be, with no explanation as to why. My urethra was destroyed due to poor surgical technique, improper catheter and stent placement and/or type, negligence, and Dr. Berli trying to make my penis too small. Dr. Berli often made excuses and gaslighted me with regards to surgical errors and outcome, in addition to placing his own personal values on to my body, including donor site choice. My penis should have been opened from the tip down to natal urethra, and all dead urethra tissue removed instead of multiple rounds of oral and IV antibiotics, unnecessary surgery, and dead tissue sloughing out of my body for months. A large painful hematoma in my donor leg went ignored, causing continuing pain and mobility problems, and delayed healing. My ALT flap pedicle was too short/tight and should've been cut and treated as a free flap. Instead, my penis is way off-center and pulls, causing frequent pain. My perineum was supposed to be repaired, but wasn't. My scrotum wasn't really created at all, and definitely not to current industry standard. I used Oregon Patient Safety Commission's Early Discussion and Resolution process, but OHSU had no interest, and never contacted me. It took almost two months to receive my medical records.

Patient 5

I had bottom surgery with Dr. Dugi almost two years ago. I have since been having major surgery regrets, and have been battling depression brought on by these regrets. I originally went to see him for an orchiectomy and was told he wouldn't do one unless I was sure I would not later desire SRS. As doing an orchiectomy first could complicate vaginoplasty later. I was feeling

pressured by my GP to have surgery, and was talked into it by Dugi. Just prior to surgery I had lost my housing, and was planning on moving out of the country so my partner could support me. I told Dugi this during the consult before surgery, and was not advised against going through surgery during this transitional and unstable time in my life. Prior to surgery I had been expressing reservations to my therapist who wrote one of my letters, and was hesitating the day of surgery to begin. I was asked after being administered part of the anesthetic, before going under to sign consent papers. I believe I was coerced into this surgery by my doctors for whatever reason. I felt like as soon as it had been covered by insurance, I was rushed into it and not given proper informed consent.

My visit in the hospital was not great, either. I was handled very roughly by a nurse during a bath and was hit in my surgery area two days after. I brought this to the head nurses attention. From the first day of my stay my attending doctors had been telling me that they wanted me to try to leave earlier than scheduled, and I ended up being pushed out of the hospital before I was ready. I have had complications after surgery, including granulation tissue, suture break, and extreme inflammation of the area. My labia were made much larger than what is normal. My surgery was several hours longer than Dr. Dugi told me it would be. I have been told his surgery technique takes longer than any other doctor. My aftercare instructions were sub par and I ending up using my wife's after care instructions from her vaginoplasty with another physician. I continue to deal with the significant aesthetic issues and internal hair growth.

Patient 6

I had vaginoplasty in January with Dr. Dugi. I was off work for 8 weeks on medical leave. I had a series of post-op appointments after my surgery. I voiced concerns, as I felt like I was not urinating normally, and was assured that everything was fine. I experienced a "waterfall effect" when I was urinating, with no control over urine stream. My urethra lacks external structure to guide urine flow. I knew it was a major surgery, and the reality is that it would take time to heal. I knew for sure that there was something wrong when I began to experience discharge, and became sick. I was evaluated, and it was determined that I had MRSA. I had no history of MRSA. I was on sulfa for a month to eradicate the infection. Today, my vagina looks different than most cisgender women's vaginas. My clitoris looks different, and is significantly too large. The urethra still looks odd, and has maintained a swollen appearance while still causing urine flow issues. I have had an issue with either a cyst, or a hematoma at the vaginal entrance, and was seen for a gynecological exam recently. Hopefully, it goes away with time. I may need a corrective procedure on my urethra, and I will surely need a labiaplasty procedure, as the single-step surgery was not efficient to yield anatomical results.

Patient 7

I had a bilateral mastectomy in March 2015 with Dr. Hansen. Early on in the process I expressed a concern around the fact that I previously had a blood clot due to an injury. In addition, clotting disorders run in my family. I was sent to a hematologist who within a 10 minute meeting determined that I was at no risk for future issues. I continued to express a concern surround the potential with blood clots as a result of my surgery and Dr. Hansen on the day of surgery did

give me a single dose of an injectable blood thinner. She had also planned to keep me overnight for observation. This plan changed however, when I was out of surgery. I was released the same day and sent home to recover with no additional blood thinner. Three days after being released from the hospital I began to have severe breathing issues and went to the emergency room for an evaluation. At that time, they found that I had 7 pulmonary embolisms and I was admitted for care. I spent nearly a week in the hospital and was scheduled to see a hematologist prior to my release, so that I may be placed on a long term medication. The attending physician canceled this order. When I pushed back about seeing the hematologist I was told I must just choose a medication so that I could be released, the attending physician felt that running additional tests wasn't warranted as it would be costly to insurance. I was covered by OHP at that time. As of today it has been over two years, and I am scheduled to have a revision surgery. I have further work that must be done to correct a fluid pocket that was left, as well as additional liposuction that needs to be done to my underarm area. My surgical results are sub-par. It is also likely that I will have to have my nipples redone, as they continue to have issues with discharge from improperly removed milk ducts. To say that I am unhappy with my experience would be a vast understatement.

Patient 8

I experienced a handful of issues related to my chest surgery at OHSU with Dr. Hansen in July 2016. I initially was referred to OHSU for surgery in early 2015, and letters were sent in my behalf for referral. OHSU lost the first letters sent, and required me to send them in another time. From the point of referral until I was in for a consult, was a span of 6 months. At the consult, I was told that I would hear from scheduling within 2 weeks to get a surgery date. It ended up taking 2 months of me calling them repeatedly before the date was scheduled. The date was set for August of 2016. In July, I received a call from scheduling saying that Dr. Hansen would not be able to perform the surgery in August, and my options were to push it to December with Dr. Berli or to have surgery with Dr. Hansen in 4 days. I had just started a new job, and was going to be losing Medicaid insurance, and because of the worry about starting the process over with insurance, I decided to go forward with surgery. This meant that the time off I had requested had to be moved up. As a result, I experienced a series of financial issues because of the poor planning, and ended up being off work for the entire summer.

On surgery day, I checked in to OHSU at 6am. I was taken for surgery at 8am, and came out of surgery around 11am. I was out of the hospital by 1pm, and home by 2pm. I felt like I was rushed out of the hospital, and I don't really know why. I developed a blood clot from surgery on my chest and abdomen, a type called Mondor disease. I reported this to OHSU as soon as symptoms were noticed, and was assured it was nothing to be concerned about. It was nearly impossible to get ahold of anyone at OHSU during this time, and repeated calls were not returned. It was not until my 3 month check with Dr. Hansen that I was told it was a blood clot.

I have some neurological issues from surgery, and have uneven chest sensation. I have one nipple that looks good, and one that looks like it is melting. That nipple has uneven edges and just looks poor. I also have a skin protrusion in the center that sticks up off of the scar line. Both

will need to be surgically fixed, but according to OHSU, both are cosmetic and not covered by insurance. I am thankful I was able to access surgery, but I would really like to have my results fixed. I can not afford to do so without insurance coverage, and I feel that my surgical results are not very good.

Patient 9

I had surgery with Dr. Dugi within the last year. The procedure itself went fine, and I have been lucky enough to not have any major complications from the surgery so far, however I have found the care given afterwards extremely lacking. After the procedure, I was enduring quite a bit of pain but was able to endure the first day since I had control over my pain medication with a button. However, after that first day I was pressured to get off of the injectable medication and onto the pills, despite how much pain I was in and explaining repeatedly the pills weren't strong enough; I was simply told "this is hospital policy". They disconnected the IV, and I had to practically beg each time I wanted the injectable, but would always be told to use the pills and wait an hour. It was a horrible, demeaning experience as the nurses (not all of them of course, but several that took care of me) began to come to my room less and less, and it would take up to 4 presses of the nurse call button for someone to show up. Sometimes they didn't at all.

I know I'm not the only one who has experienced this withholding of pain medication, or who has experienced certain nurses… dislike. This is an extremely vulnerable and, for many trans people, scary time because we are literally dependent on strangers for everything and that can be triggering for some of us. So when you have nursing staff dismissing you and your needs, and even looking at you with cold eyes, how can you be expected to heal properly? The staff needs proper training on caring for trans people, hire more staff (seriously), the pain management policy needs changing (example, the IV button for pain meds? 2 days not 1), and the patients' needs should be the first thought, not what's more economical for the hospital.

Recommendations

Enhanced Surgical Training

We desire to see policy implemented to require surgical training requirements for the THP surgeons, as mentioned in the WPATH Standards of Care for Transsexual, Transgender and Gender-Nonconforming People (SOC), version 7:

> *Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons must be willing to have their surgical skills reviewed by their peers. An official audit of surgical outcomes and publication of these results would be greatly reassuring to both referring health professionals and patients. Surgeons should regularly attend professional meetings where new techniques are presented.* (Coleman, 2012).

Specific to genital surgeries, we believe that in order to effectively perform these highly complex, nuanced surgeries, a surgeon needs to spend significant time in training with other physicians with documented, quality outcomes, and rates of complication within a set, normal range. To this end, some data suggests that decreases in rates of complication and in surgery time are achieved when the first 35 surgeries performed by a surgeon are supervised, and part of a larger training program that involves a multi-disciplinary approach to surgical care (Falcone, 2017; Schechter, 2017). We are not alone in these ideas.

A brief was published this month in The Journal of The American Society of Plastic Surgeons, discussing the same topic by physicians who perform these surgeries. Particularly poignant here, is this excerpt:

> *...There are unique challenges that are inherent in taking care of transgender patients. The World Professional Association for Transgender Health Clinical Guidelines establish a framework for delivering truly comprehensive, collaborative care, a model that goes beyond time spent in the operating room.4 To consider surgery alone, there are 43 different procedures that can be performed for both male-to-female and female-to-male patients. The surgical algorithm must be optimized for each individual. Preoperatively, clinicians must understand World Professional Association for Transgender Health guidelines and appreciate the medical, legal, and ethical implications of their work.2 For example, hospital administration will not prevent a credentialed surgeon from booking a phalloplasty for a transmale patient; however, if the surgeon did not ensure that two high-quality letters were obtained from different mental health specialists, they could be placing the patient, themselves, and the hospital at risk. There are also numerous postoperative concerns to consider as well. Surely, these are accepted realities for any surgeon, but proficiency in managing these complications can only come by means of extensive experience, which is certainly in excess of 18 hours during residency training...*
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> *...Many U.S. hospitals have begun mandating that surgeons who seek to perform gender-affirmation surgery be fellowship trained in the field or be proctored by an already credentialed gender surgeon. Weekend instructional courses on gender surgery, for all their utility and importance, will not provide the surgeon with sufficient training and skills to perform these complex procedures, thereby placing the patient at increased risk of morbidity and mortality...* (Salgado, Nugent & Kuhn, 2018).

We believe that the current standard of training for surgeons treating patients at the THP at OHSU is not sufficient to meet the benchmarks within the SOC or evidenced-based practices referenced here. We believe that the surgical process in the THP at OHSU was rushed to meet

patient need, and subsequently Dr. Daniel Dugi and Dr. Jens Berli were not prepared to begin surgical practice at the times they did.

Data Collection, Evaluation & Independent Review

We seek the implementation of a comprehensive data collection tool, independent evaluation of that data and finally, patient and medical community sharing of that scrubbed data. Separate from the purposes of determining outcomes for the sake of patients, if we want to see significant advances in care for Transgender patients, data collection and assessment must become a standardized process in this realm of medicine (Zurada, 2018).

Research shows surgical complications and patient dissatisfaction with gender confirmation surgeries is 1-10% (van de Grift et al., 2017) (Rossi Neto et al, 2012). It is clear based on the narratives above in contrast, that something is awry. And even aside from our narratives spoken here, there were an additional 7 surgical patients who did not take part in narrative. To be honest, the number of 'issues' we are aware of, represent higher rates of complications than what are expected with these surgeries.

We feel the THP at OHSU has not been honest in reporting its outcomes thus far. While there is not currently a data system tracking outcomes for patients, the program has publicly stated that there have been a total of 3 surgical complications. We need a standardized process of assessment, with agreed upon benchmarks as determined by patients and surgeons (such as starting at the point of referral, and ending at a point of 2 years post-operative, with strategic points of query installed along the track.). Ethical concerns abound when surgeons self-report their data, and determine the variable of success on behalf of the patient at the points of query. Further concerns are found when the THP is reporting a number significantly lower than what is factual based on patient stories. This discrepancy must be addressed by the THP at OHSU immediately.

Once a system is in place to assess these patient experiences, through a collaborative process that centers the perspectives of patient's reported experiences, the data must be collected and then analyzed by a 3rd party. There is onus on the THP at OHSU to work with WPATH, individual surgeons in other locations and other centers for Transgender surgery, to collaboratively develop tools for assessing outcomes that will facilitate data sharing and growth within this sphere of medicine.

Staff Expansion

We feel as though the current division of power within the THP at OHSU is leading to some of the mentioned failures. We would like to see a newly-hired, non-surgical medical director. The insular nature of the current power structure is not effective to yield satisfactory outcomes, as several of us have witnessed delays while we waited for a surgeon to decide on something related to our care, that they alone should not be making decisions on: items like scheduling order, significant infection management in aftercare and personally handling surgical prerequisites like letters. The burden of the THP in its entirety can not fall solely onto the shoulders of a physician,

whereas this will yield stress and exhaustion for the surgeon, and will further remove Trans voices from these processes.

It is no longer acceptable that the THP at OHSU does not employ a Trans woman. As the program expands, specific and unrelenting efforts must be made to hire someone into a leadership role, who comes from the community the program is serving.

Formal Grievance Procedure

We desire to see the creation of formal policy and procedure for grievance and escalation at the THP at OHSU. A written plan, separate from that of the hospital, that allows for resolution to grievances from patients. The role of general patient advocates at OHSU have not been effective for any of us, and we wish to have actual options, aside from just being handed off to Risk Management, as has happened to many of us when we complained. We would like to see a team created of both patients and physicians, who work together to mediate escalated occurrences between the program and the patient.

Community Advisory Board

In order for the THP at OHSU to be working toward becoming a Center of Excellence for Transgender Care, the addition of a CAB is necessary. The incorporation of stakeholder voices in the further development and growth of the THP at OHSU could have brought some or all of these issues to light previously, or prevented them from happening. It is rather egregious for a healthcare program to presume to understand the needs and experiences of a population, if they don't include such population in programmatic decision-making and assessment.

Ideally, the role of a CAB in this context would be to bring community voice to policy and procedure development as the above changes are implemented, to review scrubbed data as it comes out of the system, and to generally rebuild trust within this community. Part of the role of a CAB, as much as it is to inform the institution and processes, is a benefit to the organization by the sharing of information from CAB members back to their community.

Trauma Informed System of Care

A common thread that wove through most of our experiences, in all areas of the program, was a lack of empathy toward us as patients. Systemic failures exist within the program that have lead us as patients to become more medically traumatized, rather than experiencing healing as a result of surgical intervention. For some of us, it was being put through months of back and forth on whether the THP at OHSU could even provide us surgery. For some of us, it was poor aftercare, where our needs were not listened to. For some of us, it was issues with nursing staff or pain management. For several, it was medical staff making significant mistakes with medication contraindications- and administering drugs that our medical record clearly stated were to be avoided. For many of us, it was also poor surgical outcomes and multiple complications due to inadequate, and limited surgical training specific to gender-affirming surgery.

The THP states “we recognize that we have continued steps to take to improve our care and ensure gender-affirming care is trauma informed care at each and every contact (Guerriero & Penkin, 2018). In general, our experiences at OHSU created more harm. Gender-affirming care is not, by default, trauma-informed care, unless the program has taken measure to inform the larger system of culturally-specific traumas faced by our population. What steps have been taken to ensure that the THP surgeons at OHSU are qualified to perform gender-affirming surgery according to preferred current industry standards? OHSU surgeons had extremely limited experience and expertise prior to performing surgery. “Lots of experience” is not one week, nor six weeks, nor having a “mentor” or learning from other surgeons who are also extremely inexperienced (Berli, 2017).

A dedicated resident/fellow training in trans care, presence in the academic environment, and multiple new hires can not be “2017 Accomplishments” without knowledge of, surgical experience, nor expertise in performing gender affirming surgeries according to preferred current industry standards (Dugi, 2016). The only way to truly address this issue is for surgeons, such as Dr. Dugi, Dr. Berli, etc. and OHSU to lead the way and encourage fellow surgeons to create professional boards and certifying bodies for gender-affirming surgery. Until that happens, OHSU must provide future surgeons with the THP program, in-depth, lengthy resident/fellow programs with measurable means of testing their readiness to perform surgery. At this time, OHSU should send current and future surgeons to such resident/fellow programs with surgical teams recognized by trans surgery communities to have stellar reputations, having done hundreds of successful surgeries.

The THP is aware that serious harm and trauma has been inflicted on numerous trans patients at the hands of their inexperienced surgeons. “What surgeons need to know about gender confirmation surgery when providing care for transgender individuals…” is that just because a handful of patients are now receiving acceptable surgical results, does not excuse nor give a pass to all the harm and trauma inflicted on numerous previous patients who were used for practice in the THP at OHSU (Berli et al., 2017). It does not erase the fact that surgeons who are part of OHSU’s THP were far from experienced and ready to perform gender-affirming surgeries on some of society's most vulnerable populations. It is *unconscionable* to perform surgery on patients having second thoughts. (see patient #5) The undersigned, and *many* more who would like to be part of this process, but are fearful of continued harm by OHSU, or losing healthcare, have not received the “skilled clinical care” that the THP purports to give (Penkin, 2017).

Conclusion

We anticipate that this letter has struck a soft spot for most involved in the THP at OHSU. Our intention is one of change, and we desire to move medical and surgical care for Transgender people forward. This is not a personal attack against the THP or OHSU— it is however a very personal mission for those of us who are making these asks. We have been subjected to mediocre medical care for too long, and had our voices left out of conversations for evolution.

Frankly, it is our experience that Trans people, out of necessity, have evolved over time to be more educated about our medical care than most physicians offering care. Our limited options over decades made us experts, and we can not now return to a time as uneducated consumers, thankful for breadcrumbs.

What is perhaps the most troubling to us, are the demographics associated with who is accessing surgery at the THP at OHSU. While OHSU is not responsible for holding a monopoly on genital surgery options, the fact remains that most recipients of Medicaid in Oregon who seek these surgeries, are funneled toward the THP at OHSU. The intersection of no additional options for low-income folks on Medicaid, and a program that has had as many issues as the THP has, means that too many people have come out of the program harmed without the financial or social means to do anything about it. Association can be made with historic narratives involving certain minority populations being used as test subjects by doctors. While we do not believe that this is the intention on the part of the THP, the facts remain.

It is our hope that upon the receipt of this letter and narratives, that immediate action is taken to work on these issues. We believe in a THP that works with and for Transgender people, that serves to heal institutional medical trauma and provides the best care for our community. For this end, we expect you to respond with action items no later than August 23rd, 2018. If response has not been received on August 24th, 2018 this letter will be made public.

Signed,

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