

**IN THE UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF ARKANSAS  
CENTRAL DIVISION**

**DYLAN BRANDT, et al.,**

**PLAINTIFFS**

**v.**

**Case No. 4:21-CV-00450-JM**

**LESLIE RUTLEDGE, et al.,**

**DEFENDANTS**

**PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION**

Pursuant to Federal Rule of Civil Procedure 65, Plaintiffs hereby move the Court to enter a preliminary injunction that restrains Defendants and successors in office from enforcing any provision of House Bill 1570, Act 626 of the 93rd General Assembly of Arkansas, to be codified at ARK. CODE ANN. §§ 20-9-1501 to 20-9-1504 and 23-79-164, during the pendency of this litigation.

In support of this Motion, Plaintiffs submit the following:

- Exhibit 1 - Declaration of Dylan Brandt in Support of Plaintiffs' Motion for a Preliminary Injunction;
- Exhibit 2 - Declaration of Joanna Brandt in Support of Plaintiffs' Motion for a Preliminary Injunction;
- Exhibit 3 - Declaration of Sabrina Jennen in Support of Plaintiffs' Motion for a Preliminary Injunction;

- Exhibit 4 - Declaration of Aaron and Lacey Jennen in Support of Plaintiffs' Motion for a Preliminary Injunction;
- Exhibit 5 - Declaration of Brooke Dennis in Support of Plaintiffs' Motion for a Preliminary Injunction;
- Exhibit 6 - Declaration of Shayne and Amanda Dennis in Support of Plaintiffs' Motion for a Preliminary Injunction;
- Exhibit 7 - Declaration of Parker Saxton in Support of Plaintiffs' Motion for a Preliminary Injunction;
- Exhibit 8 - Declaration of Donnie Saxton in Support of Plaintiffs' Motion for a Preliminary Injunction;
- Exhibit 9 - Declaration of Dr. Michele Hutchison in Support of Plaintiffs' Motion for a Preliminary Injunction;
- Exhibit 10 - Declaration of Dr. Kathryn Stambough in Support of Plaintiffs' Motion for a Preliminary Injunction;
- Exhibit 11 - Declaration of Dr. Deanna Adkins in Support of Plaintiffs' Motion for a Preliminary Injunction;
- Exhibit 12 - Declaration of Dr. Armand H. Matheny Antommara in Support of Plaintiffs' Motion for a Preliminary Injunction; and
- Memorandum of Law in Support of Plaintiffs' Motion for a Preliminary Injunction.

Plaintiffs' Memorandum of Law in Support of the Motion demonstrates that Plaintiffs are likely to prevail on the merits of their claims, a preliminary injunction is necessary to prevent irreparable harm to Plaintiffs, and such a preliminary injunction is in the public interest.

Dated: June 15, 2021

Respectfully submitted,

/s/ Leslie Cooper

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**IN THE UNITED STATES DISTRICT COURT FOR  
THE EASTERN DISTRICT OF ARKANSAS**

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DYLAN BRANDT, et al.,		:
	Plaintiffs,	:
		:
	v.	:
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LESLIE RUTLEDGE, et al.,		:
	Defendants.	:
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Case No.: 4:21-CV-00450-JM-01

**DECLARATION OF DYLAN BRANDT  
IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION**

I, Dylan Brandt, hereby declare as follows:

1. I offer this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction. I have personal knowledge of the facts set forth in this Declaration and could and would testify competently to those facts if called as a witness.

2. I am 15 years old, and I am a rising sophomore in high school.

3. I am transgender. I was designated as female on my birth certificate, but my gender identity is male.

4. I have known since I was in elementary school that something about my body and the sex I was assigned at birth did not feel right. Since I was first able to choose for myself I have always chosen to wear more masculine clothes and participate in activities more commonly associated with boys, like football. I felt most comfortable when other boys acted like I belonged with them.



5. My discomfort with my body increased a lot when I started puberty and my body began to change in ways that did not feel right. I did not know exactly how to describe what I was feeling, but now I know I was experiencing gender dysphoria.

6. I began to feel depressed and very anxious, especially in social situations. I stopped playing football and began to spend a lot more time alone.

7. In 2018, when I was in seventh grade, I cut my hair short and soon after that I finally realized that my discomfort was because I am a boy, but no one recognized that, and my body was beginning to look more and more like a girl's body.

8. After several months of thinking about this and trying to understand myself, I finally decided to tell my family. In 2019 I wrote my mom a letter and told my brother to give it to her. I told my mom in the letter that I am not her daughter, I am her son. I signed the letter as "Dylan," the name I chose.

9. My mom and I talked about it and she was very supportive. She began using he/him pronouns for me and calling me "Dylan." After that, people would sometimes recognize me as a boy, and that made me really happy. It felt right.

10. I started eighth grade using my name, Dylan. My school and most of the students were supportive, but some students were not. Some of them were mean and told me I didn't belong. Once at a football game, a classmate told me I should leave because I didn't belong there. I refused to leave and he came back a few minutes later and started reading bible verses at me. I stopped going to football games after that. I just wanted to be a normal kid and for people to stop talking about me. Because of this type of bullying, I didn't go back to school in January of 2020. My mom found an online school I could attend from home, and I have been doing school online since then.

11. My mom shared with my doctor that I had come out to her as a boy, and my doctor referred us to the Gender Spectrum Clinic. I had my first appointment there sometime in late January or early February 2020. There I met Dr. Hutchison, who took a lot of time to listen to what I was feeling and thinking. She also spent a lot of time helping me and my mom understand my treatment options, including the risks and potential side effects. Dr. Hutchison told me I had to continue to meet with my therapist regularly as long as I was being treated at the clinic. At the clinic I also spoke with a psychiatrist, a social worker, and a chaplain.

12. After meeting with Dr. Hutchison and her team, I was given my first shot of Depo-Provera to stop my period. Getting my period was a major stressor to me, and it was a big relief to start the process. It felt like a huge weight had been lifted off my chest. Having people who listened and supported me did help me deal with my depression and anxiety a little better, but what I really needed was something to help my body match who I really am. Only then did I really begin to feel like there was hope.

13. In August 2020, I met with a psychiatrist at the clinic who agreed with my other healthcare providers that hormone therapy was necessary for me. I started testosterone then, and the results have been life changing. I have been on hormone therapy for over ten months now. My voice dropped quickly, I started growing facial hair, and I have even developed an Adam's Apple.

14. I now feel a level of confidence I never knew was possible. I can easily and confidently interact with other people, whether I know them or not. My body is finally beginning to match who I am.

15. My mom had my name legally changed to Dylan in August of 2020. I was so happy I cried.

16. I plan to go back to school in person this fall. I will be a sophomore, and it will be my first time going to high school in person. I am very excited to go back now that I am getting the medical care I need and feel comfortable with myself, and now that others see me as the boy I am.

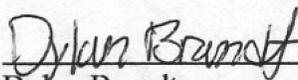
17. When I heard about the Health Care Ban, I was confused and anxious. I didn't understand why people who have never met me and who aren't doctors would try to take away treatment that has really allowed me to find happiness and hope.

18. I am very anxious about what would happen if my healthcare were cut off. I worry that I would lose all the progress I have made in terms of feeling like myself. I don't know exactly what would happen if I had to suddenly stop taking testosterone, but I am afraid my body will reverse changes that have made me feel comfortable with myself and so happy and confident. I am really afraid of how other people would treat me if that happened, especially right before I go back to high school. It would be devastating.

19. My mom has talked about trying to move out of state if the law takes effect so I can continue treatment. I have a lot of friends and family in Greenwood, and I do not want to leave. However, going back to life like it was before treatment is an unbearable thought, so I don't think we will have any other options if the law cuts off my treatment.

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

Executed in Greenwood, Arkansas on this 11<sup>th</sup> day of June, 2021.

  
Dylan Brandt

**IN THE UNITED STATES DISTRICT COURT FOR  
THE EASTERN DISTRICT OF ARKANSAS**

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DYLAN BRANDT, et al.,		:
	Plaintiffs,	:
		:
	v.	:
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LESLIE RUTLEDGE, et al.,		:
	Defendants.	:
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Case No.: 4:21-CV-00450-JM-01

**DECLARATION OF JOANNA BRANDT  
IN SUPPORT OF PLAINTIFFS’ MOTION FOR A PRELIMINARY INJUNCTION**

I, Joanna Brandt, hereby declare as follows:

1. I offer this Declaration in support of Plaintiffs’ Motion for a Preliminary Injunction. I have personal knowledge of the facts set forth in this Declaration and could and would testify competently to those facts if called as a witness.

2. I am the mother of Dylan Brandt, a fifteen-year-old boy. I live in Greenwood, Arkansas. I own a boutique in town that I have been running for over two years.

3. Sometime in or around the summer of 2019, Dylan wrote me a letter explaining that he was my son, not my daughter. His letter said he had been feeling this way for a long time but was struggling to find the words to express it.

4. Even before Dylan came out to me, he had always dressed and acted more like a boy. While I was not expecting Dylan to tell me he was transgender, it made sense to me. He had always rejected all things typically “feminine.” In seventh grade, he started experiencing depression as well as anxiety in social situations; my previously vibrant child had become shy and



withdrawn. In early 2019 he started seeing a therapist to help him deal with the depression and anxiety.

5. After Dylan wrote the letter, we talked a lot about what he had been feeling and thinking. He expressed his desire to be recognized as the boy he is, and his discomfort with his body. I started referring to him with he/him pronouns and using the name Dylan.

6. In the fall of 2019, Dylan entered the eighth grade. While most people were supportive, some students were not. Some students harassed and bullied Dylan and it was clearly increasing his anxiety and depression. Instead of sending him back to the same school in January 2020, I enrolled him in an online school.

7. I had hoped that keeping Dylan away from bullies would improve his mental health, but Dylan's depression and anxiety persisted; he continued to be quiet and withdrawn.

8. After Dylan came out, I began researching how best to support him. I read a lot about the experiences of transgender people and how to parent a transgender teenager. I wanted to be as certain as I could that I was doing what was best for my son. I asked Dylan's pediatrician for advice, and she referred us to the Gender Spectrum Clinic.

9. We had our first appointment at the Gender Spectrum Clinic in January or February of 2020. We met Dr. Hutchison, as well as a psychiatrist, a social worker, and a chaplain. Dylan was diagnosed with gender dysphoria. Dr. Hutchison spent a lot of time talking with us about what treatment options were available. She also took time to explain the requirements Dylan would have to meet before he could receive testosterone, as well as the risks and potential side effects. She told us that Dylan would have to continue to actively participate in therapy as part of his overall healthcare plan. She also asked us to consider at length whether we wanted to begin

hormone therapy, since abruptly stopping hormone treatment could have negative effects on his health. I had many conversations with Dylan in the months that followed, and we decided that starting hormone therapy was a necessary next step for him.

10. Dylan started on Depo-Provera to stop menstruation, which had been causing him to feel extremely dysphoric. Dylan seemed to experience substantial relief once he was able to be evaluated and treated by healthcare providers working to alleviate the extreme distress he felt with his body.

11. In August of 2020, Dylan underwent a psychiatric evaluation and was approved to begin hormone therapy. The psychiatrist told me she had no concerns about Dylan receiving testosterone given that his gender identity was firm and long-standing. All of Dylan's healthcare providers agreed that this treatment was necessary for Dylan's health and well-being. After having done my own research and listening to my son, I agreed, and Dylan began receiving testosterone that month.

12. I had Dylan's name legally changed in August of 2020.

13. Dylan has now been on testosterone for over ten months. He has experienced changes typical of male puberty—his voice is lower, he has facial and body hair, his face took on a more masculine shape with a square jawline, and he began to resemble my father. . The testosterone also stopped his breast development, alleviating the dysphoria it had caused and allowing him to fit more easily into clothing that made him feel comfortable. He looks like a typical fifteen-year-old boy.

14. When people first began to recognize Dylan as the boy he is, I saw his face light up every time. After beginning treatment, I watched Dylan go from an anxious, depressed,

withdrawn child to a confident, happy young man who is eager to encourage and uplift everyone around him.

15. I first learned about the Health Care Ban after the House had first passed it. I could not believe that people who had never met me or my son and who had no medical expertise would try to take away this life-saving healthcare. I was terrified for his well-being and for our family.

16. We decided to attend the Senate Public Health committee meeting to share our experience and need for gender-affirming healthcare. I spent a lot of time trying to find the right words to convey the necessity of this care, only to find that legislators had already made up their minds. Some committee members did not even bother to listen and instead talked with one another, used their cell phones, or even left the room. Dylan and I offered to let any of them speak with Dylan about his experience. No one accepted that offer.

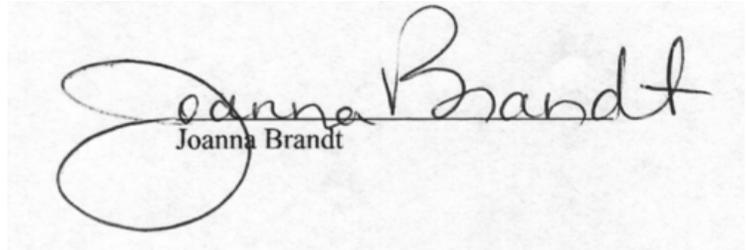
17. I am terrified about the possibility of the Health Care Ban going into effect. I can't bear the thought of Dylan losing the progress he has made physically and emotionally. I am afraid that if Dylan is forced to return to endogenous puberty, his gender dysphoria will intensify, his depression will return, and he will lose the happiness and confidence he has found since he started this treatment. I am also worried that he could face bullying in school again because of the physical changes that might come with abruptly stopping his treatment.

18. After the bill passed, I began to explore options like finding a clinic in a nearby state or moving to a state that would allow Dylan to access the care he needs. Traveling out of state for treatment would not be financially possible. Moving would not only be financially difficult—it would mean having to leave my business—it would also mean leaving family, friends,

and our home. However, it may be our only option if the Health Care Ban goes into effect and Dylan can no longer get the care he needs in Arkansas. Stopping treatment is not an option.

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

Executed in Greenwood, Arkansas on this 11<sup>th</sup> day of June, 2021.



Handwritten signature of Joanna Brandt. The signature is written in black ink and is cursive. Below the signature, the name "Joanna Brandt" is printed in a small, black, sans-serif font.

**IN THE UNITED STATES DISTRICT COURT FOR  
THE EASTERN DISTRICT OF ARKANSAS**

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DYLAN BRANDT, et al.,	:	
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Plaintiffs,	:	Case No.: 4:21-CV-00450-JM-01
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v.	:	
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LESLIE RUTLEDGE, et al.,	:	
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Defendants.	:	
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**DECLARATION OF SABRINA JENNEN  
IN SUPPORT OF PLAINTIFFS’ MOTION FOR A PRELIMINARY INJUNCTION**

I, Sabrina Jennen, hereby declare as follows:

1. I am a Plaintiff in this action. I offer this Declaration in support of Plaintiffs’ Motion for a Preliminary Injunction. I have personal knowledge of the facts set forth in this Declaration and could and would testify competently to those facts if called as a witness.

2. I am a fifteen-year-old rising junior in high school. I enjoy school. I made it to the national championships for Quiz Bowl, an academic trivia competition. I also played violin and now play the acoustic guitar, earned a black belt in Taekwondo, and enjoy gaming with friends. After high school, I plan to attend college to study medical or environmental sciences.

3. I am transgender. I was designated as male on my birth certificate, but my gender identity is female.

4. Before realizing my true gender identity, I could not see a future for myself. It was a dark time for me. I experienced depression, struggled to sleep, and engaged in self-harm.



5. I began to realize my gender identity in late 2019 and came out as a transgender girl to some of my friends. It was tough to come to terms with the fact that I am in the wrong body. I remember looking at myself in the mirror and feeling extremely depressed, because I knew that being male was not who I was. After months of contemplation and introspection, I came to the realization that I was transgender. When I realized this, I was initially distraught over what I would need to do to transition, because of societal pressures to be cisgender and the dangers of being transgender in America. As a first step, I changed the gender of my character in a game called Animal Crossing. After that, I came out to my friends, and started painting my nails and shaving my body hair. I began to feel happy and confident.

6. I told my family that I am transgender in July 2020. My parents accepted me for who I am and provided me with the love and support that I needed. The rest of my family also continuously supported me, as their first priority is that I am happy and being my true self.

7. After coming out to my family and friends, I started using feminine pronouns, wearing feminine clothing, and growing out my hair. Coming out truly saved me. Being able to come to terms with my identity felt like a weight was lifted off me. But I still struggled with the fact that my body did not match my gender.

8. I began seeing a therapist and was diagnosed with gender dysphoria in or around October, 2020.

9. In or around January 2021, with my parents' support, I began gender-affirming hormone therapy. I was prescribed a testosterone suppressant and estrogen to initiate puberty consistent with my gender identity.

10. Hormone-therapy treatment has been life-changing. Since starting hormone therapy, I have become genuinely happy and confident for the first time since I can remember. I

can finally see a future for myself. My depression has subsided. I have not engaged in self-harm. I have become more engaged with my family and community.

11. The prospect of losing access to my medical care causes me to feel extremely anxious. If my treatment is stopped, I worry that the dysphoria, depression, acts of self-harm and anxiety will come back.

12. On or around June 3, 2021, my name was legally changed to Sabrina Jennen.

13. If H.B. 1570 takes effect, seeking treatment and living out of state is my only option. I love my Fayetteville community. I have a network of friends, family, educators, and a church community that support me. My parents are lifelong Arkansans and my entire extended family lives in Arkansas. But I cannot go back to feeling how I did before receiving hormone therapy. If H.B. 1570 takes effect, I may have to leave my home state.

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

Executed in Fayetteville, Arkansas, on this 11<sup>th</sup> day of June, 2021.

  
Sabrina Jennen

IN THE UNITED STATES DISTRICT COURT FOR  
THE EASTERN DISTRICT OF ARKANSAS

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	Plaintiffs,	:	Case No.: 4:21-CV-00450-JM-01
	v.	:	
LESLIE RUTLEDGE, et al.,		:	
	Defendants.	:	
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**DECLARATION OF AARON AND LACEY JENNEN  
IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION**

We, Aaron and Lacey Jennen, hereby declare as follows:

1. We are Plaintiffs in this action. We offer this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction. We have personal knowledge of the facts set forth in this Declaration and could and would testify competently to those facts if called as witnesses.
2. We are the parents of Sabrina Jennen, a fifteen-year-old rising junior in high school. Sabrina is transgender. When Sabrina was born, she was designated as male on her birth certificate, but her gender identity is female.
3. When Sabrina first came out as transgender to us in July 2020, we immediately sought professional counseling for her. Sabrina was diagnosed with gender dysphoria around October 2020. After an extended period of therapy sessions, Sabrina asked us about seeking gender-affirming hormone therapy. We prayed about it. We had many long and serious discussions about it. We conducted rigorous research to find further information, including best practices for health care for transgender adolescents. This was a months-long process.



4. Ultimately, we sought out a consultation with a doctor who provides gender-affirming care when medically indicated, who answered our questions and concerns. In January, 2021, we, along with Sabrina and her doctors, decided that gender-affirming hormone therapy was right for her. Shortly thereafter, Sabrina was prescribed a testosterone suppressant and estrogen to initiate puberty consistent with her gender identity.

5. Hormone therapy has changed Sabrina's life. Before she began treatment, Sabrina experienced depression, struggled to sleep, and engaged in self-harm. There were times we were worried about her being left alone. Since starting hormone therapy, Sabrina's depression has subsided; she has not engaged in self-harm; and she has become more engaged with her family. Treatment has made her happy, confident, and has helped her become the thriving child we love so dearly.

6. If H.B. 1570 (the "Health Care Ban") takes effect, Sabrina's hormone therapy will be cut off. If this occurs, we fear for her survival. Sabrina is an amazing, smart, and beautiful person and an incredible daughter. We love her. We cannot bear to lose the happy and thriving young woman that Sabrina has become, nor can we return to constant concern over her safety. Sabrina not receiving this treatment is just not an option for our family. We can't go back.

7. If it goes into effect, the Health Care Ban will remove our right as parents to seek out medically-necessary health care for our daughter. After months of researching and speaking with health-care professionals, we had made the decision about the best course of action for Sabrina. We believe, as parents, this is something we should have the right to do. The Health Care Ban would take that from us and from our daughter to have the benefit of her parents acting in her best interest.

8. If the Health Care Ban takes effect, it will not prevent us from ensuring that Sabrina receives this necessary treatment. We worry that our only option to ensure Sabrina can get the care she needs will be to seek treatment outside of the State, which may require us to move out of Arkansas. As parents of a wonderful and amazing daughter, we find it distressing to consider going out of state to get Sabrina the care that her doctors, her therapists, and our family all agree is necessary for her.

9. Arkansas is our home. We have lived in Arkansas our entire lives. Our parents, siblings, grandparents, and other family, our entire support system, all of whom we are very close to, lives in Arkansas. We are proud graduates of the University of Arkansas at Fayetteville. Our professional lives and community are in Arkansas. Our church is in Arkansas.

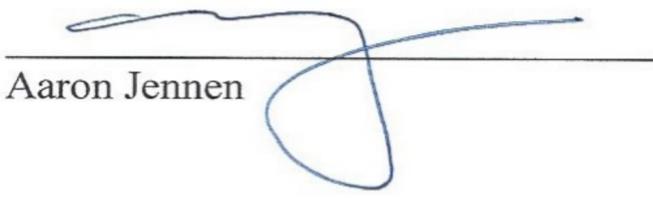
10. Sabrina has a robust network of friends, family, educators, and a church community in Fayetteville that supports her that would be difficult, if not impossible, to replace.

11. Our two other daughters, Sabrina's sisters, are also deeply connected to their school and community—one is on her school cheerleading squad and competes on the track team and in Quiz Bowl; the other takes ice skating lessons and loves school and the friends she has made there.

12. We want to continue to raise our children in beautiful Fayetteville. We do not want to leave Arkansas. But if the Health Care Ban takes effect, we believe we would have to leave in order to keep Sabrina healthy and safe.

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

Executed in Fayetteville, Arkansas, on this 11<sup>th</sup> day of June, 2021.

  
Aaron Jennen

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

Executed in Fayetteville, Arkansas, on this 11<sup>th</sup> day of June, 2021.

A handwritten signature in blue ink, appearing to read "Lacey Jennen", is written over a horizontal line.

Lacey Jennen

**IN THE UNITED STATES DISTRICT COURT FOR  
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Plaintiffs,	:	Case No.: 4:21-CV-00450-JM-01
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LESLIE RUTLEDGE, et al.,	:	:
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Defendants.	:	:
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**DECLARATION OF BROOKE DENNIS  
IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION**

I, Brooke Dennis, hereby declare as follows:

1. I am a Plaintiff in this action. I offer this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction. I have personal knowledge of the facts set forth in this Declaration and could testify competently to those facts if called as a witness.

2. I am 9 years old and am in the third grade. I love to do gymnastics and want to be a gymnast when I grow up. I like jumping on the trampoline in our backyard and can do backward somersaults.

3. For as long as I can remember, I have known I am a girl. Though I used to wear boys' clothes that my parents bought for me, I have been wearing girls' clothes for many years. I love to wear dresses and play dress-up.

4. In school, my classmates used to ask why I was in the boys' restroom, and argue about whether I am a boy or a girl.



5. One day a photographer came to our house to take pictures of our family. The photographer called me "she." I liked that the photographer saw me as a girl, and when my mom asked me afterwards how it made me feel I told her that I would prefer if everyone called me "she." I told my parents "I am Brooke and I'm a she."

6. When my parents told me that it would be okay if everyone called me "she" or "her," I was happy. I did not realize that I could ask for that. After people started calling me Brooke and using "she" and "her" when talking about me, I felt much better, like people were seeing the real me.

7. Last year I started to see a therapist to talk about my feeling about being a girl. I also went to the Gender Spectrum Clinic at Arkansas Children's Hospital and met with doctors.

8. Recently, I have noticed that my older brother is starting to change, and I am worried that one day I will change like him. I do not want to get an Adams' apple, or to look like a boy. I already feel like I look different than the other girls at school, and I am afraid of looking even more different.

9. My parents explained to me that a new law will make it more difficult for me and other kids like me to get medical care to live as the girls or boys we are. This makes me sad and worried.

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

Executed in Bentonville, Arkansas on this 11<sup>th</sup> day of June, 2021.

Brooke Dennis  
Brooke Dennis



the tree because Brooke would take it off and wear it. When we visited with family, Brooke loved to play dress-up with her female cousins.

4. We used to buy Brooke traditionally boys' clothes, but when she was 4 years old, her grandma bought her colorful sneakers from the girls' section of the store. From then on, Brooke has insisted on wearing only traditionally girls' clothing.

5. As Brooke has grown older, we have seen her become upset when others do not recognize her as she recognizes herself. For example, when Brooke was in second grade we brought her to the store to buy a Halloween costume. We told her she could pick any costume in the store, but she froze. We could see that Brooke was paralyzed by anxiety—she knew she wanted a costume from the girls' section, but she was fearful of what people would say if she picked one of the costumes designated for girls. Brooke broke down in tears in the costume aisle and Amanda had to comfort her.

6. At school, Brooke experienced significant distress related to not being understood as a girl and frequently came home crying. Brooke felt anxious and got upset when classmates would openly debate whether she is a boy or a girl or when she was asked to line up in the boys' line at school. These experiences caused Brooke to be visibly upset, and to act out at home. During the 2019-2020 school year, Brooke started going to the school counselor regularly. She was not the happy child she used to be.

7. In April 2020, we had a photographer come to the house to take family portraits. During the photoshoot, the photographer used female pronouns with Brooke, and we noticed that Brooke did not correct her. After the photo shoot, Amanda asked Brooke how that made her feel. Brooke told her that she liked it and would prefer if people used female pronouns. We told her that would be fine, and Brooke declared, "I am Brooke and I'm a she."

8. After that moment, it was as if a cloud lifted and Brooke's smile came back. We had a happy, bright-eyed child again, and we were relieved to see our child flourishing once more. Since then, we have referred to Brooke with female pronouns at home, as have her grandparents, her teachers, and others in our broader community.

9. After the conversation about pronouns last April, we had Brooke begin therapy with a counselor experienced with youth experiencing an incongruence between their gender identity and assigned sex at birth. The counselor diagnosed Brooke with gender dysphoria in June 2020, and referred us to the Gender Spectrum Clinic at Arkansas Children's Hospital (the "Clinic").

10. We had our first appointment with the Clinic in October 2020. At that appointment, Brooke's physician provided us with information about gender dysphoria and the standards of treatment. The doctor told us to closely watch Brooke for signs of puberty, and advised us that puberty-delaying treatment could begin after the onset of puberty. We will have regular check-in appointments with the Clinic to monitor Brooke's development.

11. We understand that, at 9 years of age, puberty could begin for Brooke at any time. From our conversations with and observations of her, it is clear to us that Brooke is already anxious about the prospect of going through a typical male puberty. She has expressed worry to us about how her body is different than the girls at school. Brooke has a 12-year old brother, and we have watched her see the changes he is going through as he undergoes puberty. Recently, Brooke came to Amanda crying saying she did not want to get an Adam's apple.

12. Because we can see that Brooke is already so anxious about puberty, when she starts puberty we plan to start her on puberty-delaying treatment, which have been recommended by her doctors. We understand that puberty-delaying treatment is critical to prevent

the distress of going through a typical male puberty. We also understand that puberty-delaying treatment will give us time to assess whether gender-affirming hormone therapy will be medically necessary to keep Brooke healthy and initiate a puberty consistent with her female gender.

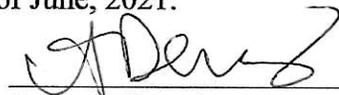
13. We are worried about not being able to obtain puberty-delaying treatment for Brooke when puberty begins. We promised our children we would always protect them, and for Brooke that means ensuring she has access to the healthcare that she needs, and that her doctors have agreed is medically necessary for her. We have already begun exploring our options for flying to another state for treatment if the law prevents Brooke from receiving puberty-delaying treatment in Arkansas. However, we understand that Brooke could need regular visits to ensure that the treatment is administered safely and effectively, and this is not a sustainable option financially. Further, we understand that the law would prevent Brooke's physicians from referring her to a doctor in a state where gender-affirming care is not prohibited and it feels risky to try to find medical care on our own without the support and expertise of the doctors at the Gender Spectrum Clinic.

14. We are left with the choice of staying in our home state or moving. If necessary to get Brooke the treatment she needs, we will move. But we will be doing so at a great cost—we have developed close ties to our community through friendships, the children's schools, and Amanda's job in leadership development at Walmart. We would also be moving away from our families, including Shayne's elderly parents for whom we provide supportive care.

15. We will do what is necessary to protect Brooke's health and well-being, but we believe that we should not be forced to leave our home state to do so.

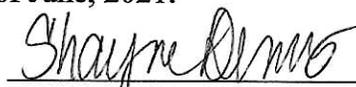
I declare under penalty of perjury that the foregoing is true and correct.

Executed in Bentonville, Arkansas on this 11<sup>th</sup> day of June, 2021.

  
\_\_\_\_\_  
Amanda Dennis

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

Executed in Bentonville, Arkansas on this 11<sup>th</sup> day of June, 2021.

  
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Shayne Dennis

IN THE UNITED STATES DISTRICT COURT FOR  
THE EASTERN DISTRICT OF ARKANSAS

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DYLAN BRANDT, et al., :
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Plaintiffs, : Case No.: 4:21-CV-00450-JM-01  
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v. :
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LESLIE RUTLEDGE, et al., :
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Defendants. :
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**DECLARATION OF PARKER SAXTON  
IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION**

I, Parker Saxton, hereby declare as follows:

1. I am a Plaintiff in this action. I offer this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction. I have personal knowledge of the facts set forth in this Declaration and could and would testify competently to those facts if called as a witness.

2. I am 16 years old and a sophomore in high school. I sing in the school choir, and I am learning how to play the guitar.

3. I am transgender. I was designated as female on my birth certificate, but my gender identity is male.

4. Though I did not have the words to identify as transgender until I was much older, for as long as I can remember, I never felt like a girl. When I was young, my mother used to joke that my theme song was "If I Were a Boy" by Beyoncé. That felt right to me.

5. When I was 11 years old I cut my hair short and, starting in the seventh grade, I dressed exclusively in clothes traditionally viewed as masculine.



6. I have always faced really bad anxiety about having to use public restrooms, and have avoided doing so for as long as I can remember. When I started puberty, my anxiety worsened. I started wearing four or five sports bras at a time to hide my body. To this day, I find it difficult to see myself in the mirror when I get out of the shower, and cannot bring myself to wear a bathing suit.

7. When I was around 13 years old, I came out to my dad as transgender. I wrote my dad a letter explaining that I was a boy, and asking him to refer to me by male pronouns and to call me by a male version of my birth name. Later, I chose the name Parker. My dad has been very supportive of me.

8. After I came out to my dad, I took further steps to socially transition. I started introducing myself with a male name and asked that I be referred to by male pronouns. I came out to my choir community, and since then I have worn a tuxedo during formal choir performances.

9. Taking steps to socially transition helped alleviate some of my anxiety, but it did not change my extreme discomfort with my body. I asked my dad to take me to receive gender-affirming medical care. In 2019, we went to the Gender Spectrum Clinic at Arkansas Children's Hospital, where I was diagnosed with gender dysphoria.

10. The first treatment I began at the Clinic was Depo-Provera to stop menstruation, which had caused me significant distress. I have been getting that treatment since the fall of 2019. This greatly eased my anxiety, and I was able to stop taking the Zoloft I had been taking to manage my anxiety and depression.

11. My doctor told me that the next course of treatment I could begin was testosterone. I felt ready to start taking testosterone to get more relief from my gender dysphoria.

Then, I found out that the General Assembly was considering the Health Care Ban, which would take that option away from me. I was devastated when I heard about the law—I had been hoping to start testosterone for so long, and it felt like those hopes had been crushed and that all the terrible feelings I had about my body would return and get worse. My dad and I were worried about what would happen to me if I started testosterone and then abruptly stopped the treatment if the law passed.

12. After I found out the Health Care Ban passed, my anxiety worsened again. I had to resume taking medication for anxiety, which seemed like a step backwards.

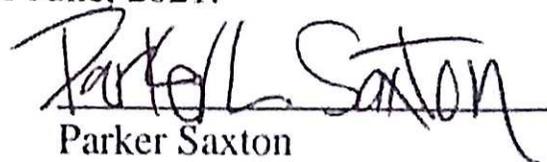
13. My dysphoria has been so severe that, together with the advice of my doctor, my dad and I decided that I would begin testosterone even though I am at risk of having this treatment abruptly stopped because of the new law.

14. I received my first testosterone shot on May 27, 2021. Getting the first shot was a great feeling because it was the start of something I have wanted for a long time. It felt like things were starting to go my way. I have had happy moments throughout my life, but this was better—this felt like a huge milestone.

15. Though I know this treatment is my best chance at alleviating the distress I feel from gender dysphoria, I also do not want to have to move. I have spent my entire life in Arkansas, and I feel safe in my community. I have family, friends, and a choir community who support me here. My sisters and my dad also feel at home and connected to the community in Arkansas. But I cannot go back to the way I was living before I started treatment, and moving might be the only way to preserve the progress I have made.

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

Executed in Conway, Arkansas on this 12<sup>th</sup> day of June, 2021.

  
Parker Saxton



avoided using them. When he was 11 years old, Parker cut his hair short and, starting in the seventh grade, dressed exclusively in boys' clothes.

5. I have not always understood what it means to be transgender, and I did not always support transgender rights. But as I watched Parker suffer, I learned more and am trying to understand what he is going through. With Parker, I started to understand that he experiences distress every time he looks in the mirror. He just wants to look in the mirror and see the person that he is on the inside staring back at him so that he can go about his day. I wish I could say that my child has spent his entire life being comfortable in his skin, but that is just not true for Parker.

6. Though it took me some time to get used to using male pronouns with Parker, now they flow easily for me. I am proud and supportive of my son and call him "my little dude". I just want to help him be able to see himself the way he feels on the inside.

7. After Parker came out as transgender, I observed him take further steps to live as a boy. He started introducing himself with a male name and asked that he be referred to by male pronouns. At formal choir performances, Parker has been wearing a tuxedo.

8. Though I have observed, and Parker has told me, that taking steps to live as the young man he is has helped him feel more like himself, I have also observed him continue to struggle with his body not matching his gender identity. Parker told me that he began wearing four or five sports bras at a time in an effort to change the physical appearance of his body; he also told me that he feels uncomfortable getting out of the shower and viewing himself in a mirror. I have observed that he refuses to participate in activities that would require him to wear a bathing suit.

9. Parker asked me to take him to receive medical care to help change his physical appearance to match his male gender. In 2019, I took him to the Gender Spectrum Clinic

at Arkansas Children's Hospital. There, Parker was diagnosed with gender dysphoria. The first step Parker's doctors recommended was that he be treated with Depo-Provera to stop menstruation because that caused him significant distress. Parker has been getting that treatment since the fall of 2019.

10. Parker's mental health greatly improved after he started receiving healthcare to treat his gender dysphoria. As a result, he was able to stop taking the Zoloft that he had been taking to manage his anxiety and depression.

11. Because Parker responded so well to receiving this treatment but was still struggling from gender dysphoria, and his gender identity has been consistent for so long, we decided, together with his doctors, that he should begin taking testosterone.

12. Parker began receiving testosterone injections on May 27, 2021. Since that time, I think Parker has been the most himself and in the best mood since he was seven years old. We have waited a long time for this.

13. After watching him make great strides under the care of his doctors and from his treatment for gender dysphoria, it was devastating to observe Parker's anxiety worsen when he learned about the General Assembly's effort to pass the Health Care Ban. As a result of the new law he had to resume taking medication for anxiety. I started sleeping on the couch close to Parker's bedroom because I realized Parker's sleep has been disturbed—I wanted to ensure I am available to provide emotional support if he needs it no matter what time it is.

14. I worry about the potential physical and mental health consequences of Parker beginning testosterone and then having to stop, but I have realized that not taking testosterone is not an option for Parker. If the Health Care Ban goes into effect, we will explore leaving the state so he can continue to receive treatment.

15. Moving out-of-state would be very difficult for us, but we will do it if necessary to ensure Parker can continue his treatment. I have lived in Arkansas my entire life, and have raised my family here. I own a plumbing business here, and moving would jeopardize our family's financial stability. It would also separate us from my parents, with whom we have a close, supportive relationship, and other relatives.

16. Conway, Arkansas is our home. We are part of the community, and I know Parker is safe surrounded by the community that has known him his entire life. I worry that if we move, we will not find the same support and connection elsewhere. I should not have to make the choice between getting healthcare for my son and keeping my family in their home.

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

Executed in Conway, Arkansas on this 12<sup>th</sup> day of June, 2021.

  
Donnie Saxton

IN THE UNITED STATES DISTRICT COURT FOR  
THE EASTERN DISTRICT OF ARKANSAS

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DYLAN BRANDT, et al.,		:
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Plaintiffs,		:
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v.	Case No.: 4:21-CV-00450-JM-01	:
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LESLIE RUTLEDGE, et al.,		:
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Defendants.		:
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**DECLARATION OF MICHELE HUTCHISON, M.D.  
IN SUPPORT OF PLAINTIFFS’ MOTION FOR A PRELIMINARY INJUNCTION**

I, Michele Hutchison, M.D., hereby declare as follows:

1. I am a Plaintiff in this action. I am bringing my claims on behalf of myself and my patients. I offer this Declaration in support of Plaintiffs’ Motion for a Preliminary Injunction. I have personal knowledge of the facts set forth in this Declaration and could and would testify competently to those facts if called as a witness.

2. I graduated from the University of Texas Southwestern Medical School in 1999. Following medical school, I completed residency and fellowship programs in Endocrinology at the University of Texas Dallas Children’s Hospital in 2002 and Southwestern Medical School in 2004, respectively.

3. I am a pediatric endocrinologist and Associate Professor in the Department of Pediatrics, College of Medicine at the University of Arkansas for Medical Sciences, where I treat youth with a variety of endocrine conditions. Since 2018, I have also been working at the Gender Spectrum Clinic at Arkansas Children’s Hospital (the “Clinic”), which provides healthcare to transgender youth with gender dysphoria.



4. The Clinic treats patients in accordance with the standards of care developed by the World Professional Association for Transgender Health (“WPATH”) and the Endocrine Society. The Clinic has an interdisciplinary team, including mental health providers, to ensure each child receives appropriate and necessary care. We require all of our patients to be receiving mental health counseling while they are in treatment at the Clinic.

5. I have treated more than 200 youth at the Clinic since its opening. Currently, there are about 160 patients under the Clinic’s care.

6. At the Clinic, I provide puberty-delaying treatment for transgender patients with gender dysphoria at the onset of puberty when medically indicated. This treatment pauses puberty and provides the patient and their family more time to determine the long-term course of appropriate medical treatment. Such treatment also prevents patients from suffering the severe emotional and physical consequences of going through puberty that does not match their gender identity.

7. For patients whose gender identity has been persistent and consistent, I will explore gender-affirming hormone therapy (testosterone suppression and estrogen for transgender girls; testosterone for transgender boys) with patients and their families, beginning around the age of 14, and initiate such treatment if medically indicated.

8. There are no medical treatments indicated or provided for pre-pubertal children with gender dysphoria. Genital surgery is not indicated or provided for minors with gender dysphoria.

9. When Clinic patients inform me that they are moving out of state, I will provide them information about clinics and providers that provide gender-affirming medical care for transgender adolescents wherever they are moving. I consider it part of my obligation to care

for my patients to maintain continuity of care by helping them find the care they need if I am unable to continue providing such care.

10. The same treatments I provide to my transgender patients at the Clinic—puberty-delaying medication, testosterone, estrogen, and testosterone suppressants—I also provide to cisgender patients. In my general pediatric endocrinology practice, I provide puberty-delaying treatment to cisgender children with precocious puberty (initiation of puberty prior to age 8 for children assigned female at birth and prior to age 9 for children assigned male at birth). I provide testosterone to cisgender boys with delayed puberty or who have insufficient testosterone for a variety of reasons. I provide estrogen to treat cisgender girls with primary ovarian insufficiency or Turner’s Syndrome (a chromosomal condition that can cause a failure of ovaries to develop). And I provide testosterone suppressants to treat cisgender girls with polycystic ovarian syndrome, which can cause symptoms such as facial hair growth. If House Bill 1570 (the “Health Care Ban”) takes effect, I will be prohibited from providing these treatments to my transgender patients because they relate to “gender transition,” but I will be able to continue providing the same treatments to my cisgender patients to help bring their bodies into alignment with their gender.

11. If the Health Care Ban takes effect, I will not be able to treat my transgender patients with gender dysphoria in accordance with the accepted standards of care. If I were to follow the medically indicated protocols for treating gender dysphoria, I would face adverse licensing action or other judicial or administrative consequences.

12. Moreover, I am concerned that if the Health Care Ban goes into effect, the Clinic might have to close.

13. Based on my personal experience in treating hundreds of adolescents with gender dysphoria, I believe that the Health Care Ban, if permitted to take effect, will significantly and severely compromise the health of my patients. In the few months since public discussion of

the Health Care Ban began, four transgender adolescent patients of the Clinic have been admitted to the emergency room for attempted suicide, in addition to three suicide attempts by transgender adolescents who are not patients of the Clinic. My office has also received several more calls from families panicking because their children were expressing suicidal thoughts related to the prospect of losing the healthcare they rely on for their well-being.

14. This is in stark contrast to the rate of suicide attempts prior to the Health Care Ban becoming public. After reviewing my records in preparing this declaration, I have determined that in the over three year period between the time of the Clinic opening and when public discussion of the Health Care Ban began, two Clinic patients attempted suicide.

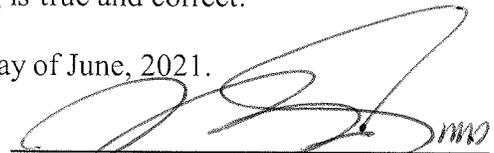
15. I testified at the General Assembly about the grave harms this bill would cause to transgender youth with gender dysphoria and that the bill would deny adolescents medical care they urgently need which, for some, can be life-saving.

16. Being forced to deny my patients medically necessary care that can be lifesaving for some patients violates the tenets of my profession by leaving my patients to suffer needless pain.

17. I am gravely concerned about my patients' ability to survive, much less thrive, if the Health Care Ban takes effect.

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

Executed in Little Rock, Arkansas, on this 14<sup>th</sup> day of June, 2021.

  
Michèle Hutchison, M.D.

**IN THE UNITED STATES DISTRICT COURT FOR  
THE EASTERN DISTRICT OF ARKANSAS**

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DYLAN BRANDT, et al.,	:	
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Plaintiffs,	:	Case No.: 4:21-CV-00450-JM-01
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v.	:	
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LESLIE RUTLEDGE, et al.,	:	
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Defendants.	:	
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**DECLARATION OF KATHRYN STAMBOUGH, M.D.  
IN SUPPORT OF PLAINTIFFS’ MOTION FOR A PRELIMINARY INJUNCTION**

I, Kathryn Stambough, M.D., hereby declare as follows:

1. I am a Plaintiff in this action. I am bringing my claims on behalf of myself and my patients. I offer this Declaration in support of Plaintiffs’ Motion for a Preliminary Injunction. I have personal knowledge of the facts set forth in this Declaration and could and would testify competently to those facts if called as a witness.

2. I graduated from medical school in 2011 and completed a residency in Obstetrics and Gynecology in 2015 at Washington University in Saint Louis. I completed a fellowship at Baylor College of Medicine/Texas Children’s Hospital that focused on Pediatric and Adolescent Gynecology. During my residency and fellowship programs, I trained in the provision of hormone therapy to treat various conditions, including gender dysphoria.

3. I am a pediatric and adolescent gynecologist in the Division of Pediatric and Adolescent Gynecology in the Department of Obstetrics and Gynecology at the University of Arkansas for Medical Sciences. My clinic is part of Arkansas Children’s Hospital. As part of my



pediatric gynecology practice, I refer patients to the Gender Spectrum Clinic at the Arkansas Children's Hospital (the "Clinic"), which provides healthcare to transgender youth with gender dysphoria.

4. For the past year, I have also worked at the Clinic one day each month. The Clinic treats patients in accordance with the standards of care developed by the World Professional Association for Transgender Health ("WPATH") and the Endocrine Society. The Clinic has an interdisciplinary team, including mental health providers, to ensure each child receives appropriate and necessary care. We require all of our patients to be receiving mental health counseling while they are in treatment at the Clinic.

5. When I am at the Clinic, I provide gender-affirming hormone therapy (testosterone suppression and estrogen for transgender girls; testosterone for transgender boys) when medically indicated for transgender patients with gender dysphoria diagnoses, beginning around the age of 14.

6. Many of the same treatments I provide to my transgender patients at the Clinic, I also provide to non-transgender patients. In my pediatric gynecology practice, I provide estrogen to non-transgender girls for a range of conditions, such as primary ovarian insufficiency, hypogonadotropic hypogonadism (delayed puberty due to lack of estrogen caused by a problem with the pituitary gland or hypothalamus), and Turner's Syndrome (a chromosomal condition that can cause a failure of ovaries to develop). I also prescribe puberty-delaying medication for non-transgender patients experiencing precocious puberty. I use that same medication—gonadotropin-releasing hormone agonist—to treat other conditions, including endometriosis. In addition, I provide other forms of hormone therapy to treat polycystic ovarian syndrome; menstrual issues including painful, irregular or heavy periods; and for menstrual suppression for patients with many

conditions including cancer and spinal cord disorders, as well as transgender boys with gender dysphoria.

7. I have had non-transgender patients with macromastia (enlarged breast size), breast hypoplasia (a lack of breast development), and breast asymmetry who I have referred to speak to a plastic surgeon regarding breast reconstruction surgery. As a result of these referrals, some of these patients have received breast reconstruction surgery.

8. If House Bill 1570 (the “Health Care Ban”) takes effect, I will be barred from treating my transgender patients with gender dysphoria in accordance with the accepted standards of care. I will thus knowingly be causing harm to my patients by following Arkansas law. If I were to follow the medically indicated protocols for treating gender dysphoria rather than the newly enacted Health Care Ban, I would face adverse licensing action or other judicial or administrative consequences.

9. Additionally, if the Health Care Ban takes effect, I would not be able to refer my patients in my gynecology practice who have gender dysphoria to the Clinic or to any other clinic that might provide gender-affirming care. My ability to make these referrals is essential to connect my patients with appropriate and necessary care, but if I were to do so, I would face adverse licensing action or other judicial or administrative consequences.

10. Moreover, I am concerned that if the Health Care Ban goes into effect, the Clinic might have to close.

11. Based on my personal experience and training, I believe that the Health Care Ban, if permitted to take effect, will significantly and severely compromise the health of my patients. Since public discussion of the Health Care Ban began, four transgender adolescent

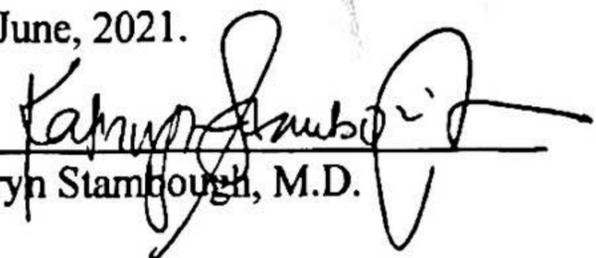
patients of the Clinic have been admitted to the emergency room for attempted suicide, in addition to three suicide attempts by transgender adolescents who are not patients of the Clinic.

12. Being forced to withhold referrals from patients at my pediatric gynecology practice, and to deny my patients at the Clinic medically necessary care that can be lifesaving for some patients, violates the tenets of my profession by leaving my patients to suffer needless pain.

13. I worry greatly about the impact on my patients if they cannot access the medically necessary and lifesaving treatment prohibited by the Health Care Ban, and fear for my patients' wellbeing.

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

Executed in Longboat Key, Florida, on this 13<sup>th</sup> day of June, 2021.

  
Kathryn Stambough, M.D.

**IN THE UNITED STATES DISTRICT COURT FOR  
THE EASTERN DISTRICT OF ARKANSAS**

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DYLAN BRANDT, et al.,	:	
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Plaintiffs,	:	Case No.: 4:21-CV-00450-JM-01
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v.	:	
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LESLIE RUTLEDGE, et al.,	:	
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Defendants.	:	
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**DECLARATION OF DEANNA ADKINS, MD**  
**IN SUPPORT OF PLAINTIFFS’ MOTION FOR A PRELIMINARY INJUNCTION**

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

2. The purpose of this declaration is to provide my expert opinions on: (1) the treatment protocols for transgender adolescents with gender dysphoria including the provision of pubertal suppression treatment and hormone therapy; and (2) the severe risk of harm to these adolescents of withholding or withdrawing this medical treatment where such treatment is medically necessary.

3. I have knowledge of the matters stated in this declaration and have collected and cite to relevant literature concerning the issues that arise in this litigation in the body of this declaration.

4. In preparing this declaration, I reviewed House Bill 1570 (the “Health Care Ban”). I also relied on my scientific education and training, my research experience, my knowledge of the scientific literature in the pertinent fields, and my clinical experience treating adolescents



with gender dysphoria. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field regularly rely upon when forming opinions on these subjects. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

### **BACKGROUND AND QUALIFICATIONS**

5. I received my medical degree from the Medical College of Georgia in 1997. I served as the Fellowship Program Director of Pediatric Endocrinology at Duke University School of Medicine for fourteen years and am currently the Director of the Duke Center for Child and Adolescent Gender Care.

6. I have been licensed to practice medicine in the state of North Carolina since 2001.

7. I have extensive experience working with children with endocrine disorders and I am an expert in the treatment of children with intersex traits, also known as differences or disorders of sex development, and in the treatment of children with gender dysphoria.

8. I am a member of the American Academy of Pediatrics, the North Carolina Pediatric Society, the Pediatric Endocrine Society, and The Endocrine Society. I am also a member of the World Professional Association for Transgender Health (“WPATH”), the leading association of medical and mental health professionals in the treatment of transgender individuals.

9. I am the founder of the Duke Center for Child and Adolescent Gender Care (“Gender Care Clinic”), which opened in 2015. I currently serve as the director of the clinic. The Gender Care Clinic sees patients between age 7 and 22 with gender dysphoria and/or

differences or disorders of sex development. I have been caring for these individuals in my routine practice for many years prior to opening the clinic.

10. I currently treat approximately 400 transgender and intersex young people from North Carolina and across the Southeast at the Gender Care clinic. I have treated approximately 500 transgender and intersex young people in my career.

11. As part of my practice, I stay familiar with the latest medical science and treatment protocols related to differences or disorders of sex development and gender dysphoria.

12. I am regularly called upon by colleagues to assist with the sex assignment of infants who cannot be classified as male or female at birth due to a range of variables in which sex-related characteristics are not completely aligned as male or female.

13. In the past four years, I was deposed and testified at trial as an expert in one case, *Adams v. The School Board of St. Johns Cty., Florida*, No. 17-CV-739 (M.D.Fla. 2017).

14. I am being compensated at an hourly rate of \$250 per hour for preparation of expert declarations and reports, and \$400 per hour for time spent preparing for or giving deposition or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

#### **GENDER IDENTITY AND GENDER DYSPHORIA**

15. A person's gender identity refers to a person's inner sense of their gender.

16. Although the precise origin of gender identity is unknown, a person's gender identity is a fundamental aspect of human development and there is a general medical consensus that there is a significant biological component to gender identity.

17. Everyone has a gender identity.

18. Most people have a gender identity that aligns with the sex they are designated at birth based on their external genitalia.<sup>1</sup> People whose sex assigned at birth aligns with their gender identity are cisgender.

19. A transgender person is someone who has a gender identity that differs from the person's sex designated at birth.

20. Many transgender children become aware of their gender identity early in life, as young as two years old. Others may not become fully aware of their gender identity until the onset of puberty or later.<sup>2</sup>

21. A person's gender identity (regardless of whether that identity matches other sex-related characteristics) is fixed, is not subject to voluntary control, cannot be voluntarily changed, and is not undermined or altered by the existence of other sex-related characteristics that do not align with it.<sup>3</sup>

22. According to the American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders ("DSM V"), "gender dysphoria" is the diagnostic term for the

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<sup>1</sup> The terms "sex designated at birth" or "sex assigned at birth" are more precise than the term "biological sex" because all of the physiological aspects of a person's sex are not always aligned with each other. For example, some people with intersex characteristics may have chromosomes typically associated with males but genitalia typically associated with females. See *Hembree WC, et al.* Endocrine treatment of gender-dysphoria/gender incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab* 2017; 102: 3869–3903, 3875, <https://academic.oup.com/jcem/article/102/11/3869/4157558> (hereafter "Endocrine Guidelines") ("Biological sex, biological male or female: These terms refer to physical aspects of maleness and femaleness. As these may not be in line with each other (e.g., a person with XY chromosomes may have female-appearing genitalia), the terms biological sex and biological male or female are imprecise and should be avoided.").

<sup>2</sup> Endocrine Guidelines at 3874-3875.

<sup>3</sup> Endocrine Guidelines at 3874.

condition where clinically significant distress results from the lack of congruence between a person's gender identity and the sex they were designated at birth. In order to be diagnosed with gender dysphoria, the incongruence must have persisted for at least six months and be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.

23. Being transgender is not itself a mental disorder or a medical condition to be cured. But gender dysphoria is a serious medical condition that, if left untreated, can result in severe anxiety and depression, self-harm, and suicidality.<sup>4</sup>

24. Before receiving treatment, many individuals with gender dysphoria have high rates of anxiety, depression and suicidal ideation. I have seen in my patients that without appropriate treatment this distress impacts every aspect of life.

25. The only effective treatment to avoid this serious harm is for the person to live in accordance with their gender identity and follow appropriate treatment protocols to affirm gender identity and alleviate distress.

26. When appropriately treated, gender dysphoria is easily managed. I currently treat hundreds of transgender patients. All of my patients have suffered from persistent gender dysphoria, which has been alleviated through clinically appropriate treatment.

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<sup>4</sup> Spack NP, Edwards-Leeper L, Feldmain HA, et al. Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*. 2012; 129(3):418-425. Olson KR, Durwood L, DeMeules M, McLaughlin KA. Mental health of transgender children who are supported in their identities. *Pediatrics*. 2016; 137:1-8.

## TREATMENT PROTOCOLS FOR PATIENTS WITH GENDER DYSPHORIA

27. The Endocrine Society and WPATH have published widely accepted standards of care for treating gender dysphoria.<sup>5</sup> The precise treatment for gender dysphoria depends on each person's individualized need, and the medical standards of care differ depending on whether the treatment is for a pre-pubertal child, an adolescent, or an adult.

28. Treatment for gender dysphoria is aimed at eliminating the clinically significant distress a patient experiences by helping the patient live in alignment with their gender identity. This treatment is sometimes referred to as “gender transition,” “transition related care,” or “gender affirming care.” All of the major medical professional groups in the United States, including the American Academy of Pediatrics, the American Medical Association and the American Academy of Child and Adolescent Psychiatry, agree that this care is safe, effective, and medically necessary treatment for the health and wellbeing of children and adolescents suffering from gender dysphoria.<sup>6</sup>

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<sup>5</sup> Endocrine Guidelines; World Prof'l Ass'n for Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (7th Version, 2011), [http://www.wpath.org/site\\_page.cfm?pk\\_association\\_webpage\\_menu=1351&pk\\_association\\_webpage=4655](http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=4655) (hereafter, WPATH SOC).

<sup>6</sup> Rafferty J, Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence and Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, *Pediatrics* October 2018; 142(4): 2018-2162; Beers, L. American Academy of Pediatrics Speaks Out Against Bills Harming Transgender Youth (March 16, 2021), <https://services.aap.org/en/news-room/news-releases/aap/2021/american-academy-of-pediatrics-speaks-out-against-bills-harming-transgender-youth/>; American Academy of Child & Adolescent Psychiatry, AACAP Statement Responding to Efforts to ban Evidence-Based Care for Transgender and Gender Diverse Youth (Nov. 8, 2019), [https://www.aacap.org/AACAP/Latest\\_News/AACAP\\_Statement\\_Responding\\_to\\_Efforts\\_to\\_ban\\_Evidence-Based\\_Care\\_for\\_Transgender\\_and\\_Gender\\_Diverse.aspx](https://www.aacap.org/AACAP/Latest_News/AACAP_Statement_Responding_to_Efforts_to_ban_Evidence-Based_Care_for_Transgender_and_Gender_Diverse.aspx); American Medical Association, State Advocacy Update (March 26, 2021), <https://www.ama-assn.org/health-care-advocacy/advocacy-update/march-26-2021-state-advocacy-update>

29. The Endocrine Society Clinical Guidelines were developed through rigorous scientific processes that “followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines.” The guidelines affirm that patients with gender dysphoria often must be treated with “a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person’s genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person’s affirmed gender.”<sup>7</sup>

30. Before puberty, treatment does not include any drug or surgical intervention. For this group of patients, treatment is limited to “social transition,” which means allowing a transgender child to live and be socially recognized in accordance with their gender identity.<sup>8</sup> This can include allowing children to wear clothing, to cut or grow their hair, to use names and pronouns, and to access restrooms and other sex-separated facilities and activities in line with their gender identity instead of the sex assigned to them at birth. Social transition is a critical part of treatment of patients with gender dysphoria of all ages and it is the only treatment for pre-pubertal children.

31. For many transgender adolescents with gender dysphoria, going through endogenous puberty can cause extreme distress. Puberty delaying treatment allows them to avoid going through their endogenous puberty thereby avoiding the heightened gender dysphoria and permanent physical changes that puberty would cause. This fully reversible treatment also gives a young person time to further understand their gender identity without the distress of

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<sup>7</sup> Endocrine Guidelines at 3869.

<sup>8</sup> Endocrine Guidelines at 3878; WPATH SOC at 15-17.

puberty and before initiating gender-affirming hormone therapy if it becomes medically indicated.

32. Puberty delaying treatment works by pausing endogenous puberty at the stage it has reached when the treatment begins. This has the impact of limiting the influence of a person's endogenous hormones on the body. For example, after the initiation of puberty delaying treatment, a girl who is transgender will experience none of the impacts of testosterone that would be typical if she underwent her full endogenous puberty.

33. Under the Endocrine Society Clinical Guidelines, transgender adolescents with gender dysphoria may be eligible for pubertal suppression if:

- A qualified mental health professional has confirmed that:
  - the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
  - gender dysphoria worsened with the onset of puberty,
  - any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,
  - has sufficient mental capacity to give informed consent to this (reversible) treatment, and
- The adolescent:
  - has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility, and

- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
- And a pediatric endocrinologist or other clinician experienced in pubertal assessment:
  - agrees with the indication for GnRH agonist treatment,
  - has confirmed that puberty has started in the adolescent, and
  - has confirmed that there are no medical contraindications to GnRH agonist treatment.

34. For some patients, initiating puberty consistent with gender identity through gender-affirming hormone therapy may also be medically necessary. Around the age of fourteen, depending on the medical needs of the patient, and the patient's mental health and medical history, gender-affirming hormone therapy can be prescribed and the adolescent will go through hormonal puberty consistent with their gender identity on a comparable timeline to their non-transgender peers.

35. Under the Endocrine Society Clinical Guidelines, transgender adolescents may be eligible for gender-affirming hormone therapy if:

- A qualified mental health professional has confirmed:
  - the persistence of gender dysphoria,
  - any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are

- stable enough to start sex hormone treatment,
- the adolescent has sufficient mental capacity to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,
- And the adolescent:
  - has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
  - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
- And a pediatric endocrinologist or other clinician experienced in pubertal induction:
  - agrees with the indication for sex hormone treatment,
  - has confirmed that there are no medical contraindications to sex hormone treatment.

36. When treating a transgender adolescent with gender dysphoria, when medically indicated, I prescribe puberty delaying treatment at the Tanner 2 stage of puberty. For people assigned male at birth, Tanner Stage 2 of puberty is typically between ages 9 and 14, and for people assigned female at birth, between ages 8 and 12. Where I first meet a patient after the patient has begun puberty, I assess the patient's individual medical needs. Depending on the patient's needs and the changes that have already been caused by their endogenous puberty, I either initiate pubertal suppression, and wait to initiate gender-affirming hormones until they are

ready; or, initiate puberty consistent with their gender identity with gender affirming hormones. The goal is to minimize the patient's dysphoria and initiate puberty consistent with gender identity within the typical age range. In my extensive clinical experience, I have observed the substantial benefits of providing individualized care to patients through pubertal suppression and gender-affirming hormones. This treatment also substantially minimizes dysphoria later in life and can eliminate the need for surgical treatment in adulthood altogether.

37. For many patients, social transition and hormone therapy are sufficient forms of treatment for gender dysphoria. Others also need one or more forms of surgical treatment to alleviate gender dysphoria. I do not perform surgery, but I refer my older patients for surgery when clinically appropriate.

38. Individuals assigned female at birth may receive chest reconstruction surgery before the age of 18 provided they have been living consistent with their gender identity for a significant period of time. Genital surgery for transgender women and men is not recommended until the person has reached the age of at least 18.

**PUBERTY BLOCKERS AND GENDER-AFFIRMING HORMONES ARE SAFE AND EFFECTIVE TREATMENTS FOR TRANSGENDER YOUTH**

39. The Endocrine Society's treatment protocols for providing puberty blockers and gender affirming hormone therapy are safe and effective treatments for gender dysphoria.

40. Puberty blockers began to be used in transgender patients in 2004, which is not considered recent in medicine. We also have over thirty years of data on the impact of puberty blockers on children who undergo precocious puberty that we can apply to the transgender population. From the more than thirty years of data that we have, there is no scientific evidence of short or long-term negative effects on patients who receive puberty blockers. And for transgender youth (as compared to those treated for precocious puberty), the treatment is used for

a much shorter period of time, in order to pause puberty before either initiating puberty with cross-sex hormones or resuming endogenous puberty. This medication is also used in adolescents and adults undergoing chemotherapy to preserve fertility and in patients with hormone sensitive cancers, like breast and prostate cancer.

41. In a 2020 study published in *Pediatrics*, the official journal of the American Academy of Pediatrics, researchers concluded that “Treatment with pubertal suppression among those who wanted it was associated with lower odds of lifetime suicidal ideation when compared with those who wanted pubertal suppression but did not receive it. Suicidality is of particular concern for this population because the estimated lifetime prevalence of suicide attempts among transgender people is as high as 40%.”<sup>9</sup>

42. As noted above, under the Endocrine Society Clinical Guidelines, once a transgender adolescent establishes further maturity and competence to make decisions about additional treatment, it may then be medically necessary and appropriate to provide gender-affirming hormone therapy to initiate puberty consistent with gender identity. For girls who are transgender this means administering both testosterone suppressing treatment as well as estrogen to initiate hormonal puberty consistent with the patient’s female gender identity. For boys who are transgender this means administering testosterone.

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<sup>9</sup> Turban JL, King D, Carswell JM, et al. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*. 2020;145(2):e20191725. Wiepjes, C. M., Nota, N. M., de Blok, C. J., Klaver, M., de Vries, A. L., Wensing-Kruger, S. A., ... & Gooren, L. J. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): trends in prevalence, treatment, and regrets. *The Journal of Sexual Medicine*, 15(4), 582-590. De Vries, A. L., McGuire, J. K., Steensma, T. D., Wagenaar, E. C., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134(4), 696-704.

43. There is nothing inherently harmful about undergoing hormone treatment to sustain one's health and it is a common practice in many non-transgender patients for reasons unrelated to treatment of gender dysphoria. Many transgender people have been on hormone therapy for decades and we are not seeing evidence of negative health outcomes as a result. Likewise, many non-transgender individuals have to undergo hormone treatment for the majority of their lives, and it is well-managed. This includes patients with various intersex conditions such as Turner syndrome and Klinefelter syndrome, premature ovarian failure, and cancer.

44. In addition to my patients with intersex traits, I regularly treat cisgender patients with the same hormone therapy that is provided to transgender patients. For example, cisgender boys with delayed puberty are often prescribed testosterone if they have not begun puberty by age 14. Without testosterone, for most of these patients, puberty would eventually initiate naturally but testosterone is often prescribed to avoid some of the social stigma that comes from undergoing puberty later than one's peers. Likewise, cisgender girls with hypogonadotropic hypogonadism (delayed puberty due to lack of estrogen caused by a problem with the pituitary gland or hypothalamus) may be treated with estrogen to initiate puberty. I also treat cisgender girls with Polycystic Ovarian Syndrome (PCOS) with hormonal birth control or testosterone suppression to reduce some symptoms of the condition including excess facial hair. Similarly, a cisgender boy and a transgender boy could both seek surgery to remove breast tissue to help align their body or appearance with their gender. In other words, as a pediatric endocrinologist I provide the same types of treatments to people with intersex traits and cisgender people to affirm their gender that is prohibited by the Health Care Ban if provided to transgender people for the same reasons.

45. One argument against treatment for transgender youth that is often raised is that the treatment is automatically sterilizing, but this is not accurate. Many people undergo fertility preservation before any treatment that would compromise fertility. Many more transgender people may be treated with gender affirming surgery that has no impact on fertility such as chest reconstruction. Many transgender individuals conceive children after undergoing hormone therapy.<sup>10</sup> More generally, many medical interventions that are necessary to preserve a person's health and well-being can impact an individual's fertility, but we proceed with the treatment after informed consent. In contrast to care for transgender youth, which can always leave room for fertility preservation, many surgical interventions performed on intersex infants – which this law permits – would permanently impact fertility. In fact, there are often no medical benefits to surgical interventions performed on intersex infants.

46. The legislative findings in the Health Care Ban also claim that “cross-sex hormones” pose serious health risks including an increase in red blood cells, severe liver dysfunction, heart attack, stroke, hypertension, increased risk of breast and uterine cancers, blood clots, gallstones, tumors of the pituitary gland, and elevated levels of triglycerides in the blood. All of these risks are rare when this treatment is provided and supervised by a clinician. These very same risks are present in the exact same way when hormone therapy is used to treat cisgender individuals. None of these risks are unique to transgender patients. Of the purported risks identified, the only ones I see regularly are increased red blood count, which is not

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<sup>10</sup> Light AD, Obedin-Maliver J, Sevelius JM, Kerns JL. Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstet Gynecol.* 2014;124(6):1120-1127; Maxwell S, Noyes N, Keefe D, Berkeley AS, Goldman KN. Pregnancy Outcomes After Fertility Preservation in Transgender Men. *Obstet Gynecol.* 2017;129(6):1031-1034; Neblett MF 2nd, Hipp HS. Fertility Considerations in Transgender Persons. *Endocrinol Metab Clin North Am.* 2019;48(2):391-402.

considered a risk as the count generally increased with testosterone to within the range that is typical for people assigned male at birth, and high cholesterol. For high cholesterol, that is largely based on family history and is identical in transgender and cisgender patients. All of these side effects are standard for hormonal medical intervention and each is increased substantially when treatment is obtained on the black market and not supervised by appropriate clinical providers.

47. Another argument against treatment for transgender youth is the inaccurate claim in the legislative findings of the Health Care Ban that for those children who “experience distress at identifying with their biological sex, studies consistently demonstrate that the majority come to identify with their biological sex in adolescence or adulthood, thereby rendering most physiological interventions unnecessary.” Adolescents with persistent gender dysphoria after reaching Tanner Stage 2 almost always persist in their gender identity in the long-term whether or not they were provided gender affirming care.<sup>11</sup> No medical treatment is provided to transgender youth until they have reached Tanner Stage 2.

48. The goal of treatment for gender dysphoria is not to make someone cisgender or transgender; it is to resolve the distress associated with the disconnect between a person’s assigned sex at birth and their gender identity. Denying puberty blockers and gender affirming hormones to a transgender adolescent will not cause the adolescent to “desist” from being transgender. It will only cause the minor to experience distress from lack of treatment.

49. Puberty delaying medication and gender-affirming hormones are only provided after careful evaluation where a patient is experiencing consistent and persistent gender

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<sup>11</sup> Turban JL, DeVries ALC, Zucker K. Gender Incongruence & Gender Dysphoria. In Martin A, Bloch MH, Volkmar FR (Editors): *Lewis’s Child and Adolescent Psychiatry: A Comprehensive Textbook*, Fifth Edition. Philadelphia: Wolters Kluwer 2018.

identification different from their assigned sex and clinically significant distress related to the incongruence. Each stage of the treatment is carefully evaluated and can be changed at any time by carefully tapering a patient off of the treatment. In the case of puberty blocking medication, once stopped, a patient's endogenous puberty begins immediately. With hormone therapy, once stopped, a patient's naturally occurring hormones will continue. This treatment does not make people transgender; it safely and effectively treats patients with gender dysphoria.

50. Treatment for transgender youth and adolescents is safe, effective and essential for the well-being of transgender young people. My patients who receive medically appropriate hormone therapy and who are treated consistent with their gender identity in all aspects of life experience significant improvement in their health. Medical treatment recommended for and provided to transgender adolescents with gender dysphoria can substantially reduce lifelong gender dysphoria and can eliminate the medical need for surgery later in life. Providing gender-affirming medical care can be lifesaving treatment and can improve the short- and long-term health outcomes for transgender youth.

#### **HARMS OF WITHHOLDING OR TERMINATING TREATMENT FOR TRANSGENDER YOUTH WITH GENDER DYSPHORIA**

51. Withholding pubertal suppression and hormone therapy from transgender young people when it is medically indicated is extremely harmful. As noted above, administration of pubertal suppression has shown to significantly reduce suicidality in transgender patients. If I was prohibited from treating my patients with this treatment where it is medically indicated, it would result in predictable and significant harms, including the at least partially irreversible changes from endogenous puberty described below.

52. From a medical perspective, it is at least as dangerous to withdraw treatment once it has been initiated as it is to withhold the initiation of treatment. If a clinician is forced to

immediately stop pubertal suppression as a result of a legal prohibition on the care, it will cause patients to immediately resume their endogenous puberty. This could result in extreme distress for patients who have been relying on the suppression to prevent bodily changes that come with their endogenous puberty. For a girl who is transgender, this could mean that she would immediately start experiencing genital growth, body hair growth, deepening of her voice and development of a more pronounced Adam's apple. For a boy who is transgender, this could mean that he would have the initiation of a menstrual cycle and breast growth. These changes can be extremely distressful for a young person who had been experiencing gender dysphoria that was then relieved by the initiation of pubertal suppression.

53. Additionally, the effects of undergoing one's endogenous puberty may not be reversible even with subsequent hormone therapy and surgery, thus exacerbating lifelong gender dysphoria in patients who would have this treatment withheld or cut off. Bodily changes from puberty as to stature, hair growth, genital growth, voice and breast development can be impossible or more difficult to counteract.

54. For patients who are currently undergoing treatment with gender-affirming hormones like estrogen or testosterone, abruptly withdrawing care can result in a range of serious physiological and mental health consequences. The body takes about six weeks to ramp up endogenous hormones so if a clinician is forced to abruptly stop treatment, a patient will be without sufficient circulating hormones at all. This can result in depressed mood, hot flashes, and headaches. For patients on spironolactone – a testosterone suppressant – abruptly terminating treatment can cause a patient's blood pressure to spike, increasing a young person's risk of heart attack or stroke. The abrupt withdrawal of treatment also results in predictable and negative mental health consequences including heightened anxiety and depression.

55. If I had to pull my patients off treatment, even for a short time, I would be concerned that some could become so traumatized they would resort to self-harm and potentially even attempt suicide. We barely save some of these young people's lives by getting them on treatment; to take them off mid-treatment could be life threatening.

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

Executed on

6/11/2021



Deanna Adkins, MD

**IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF ARKANSAS  
CENTRAL DIVISION**

DYLAN BRANDT, et al.,

Plaintiffs,

v.

LESLIE RUTLEDGE, et al.,

Defendants.

CIVIL ACTION

Case No. 4:21CV450-JM

**EXPERT DECLARATION OF  
ARMAND H. MATHENY  
ANTOMMARIA, MD, PhD, FAAP, HEC-C**

I, ARMAND H. MATHENY AN TOMMARIA, MD, PhD, FAAP, HEC-C, have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

1. This declaration provides the following expert opinions, which are explained in further detail below:

2. 2021 Arkansas House Bill 1570 (HB 1570) singles out gender transition procedures, which I will refer to as gender-affirming medical care, for anomalous treatment, prohibiting healthcare professionals from providing gender-affirming medical care to minors or referring minors for such care. I am unaware of any instances—apart from HB 1570—in which the government categorically prohibits minors and their parents or guardians from accessing a treatment supported by evidence of efficacy, let alone treatment that is widely endorsed by medical professional organizations.

3. The legislative findings in HB 1570 cite a lack of “long-term longitudinal studies” and “randomized clinical trials” to support prohibiting gender-affirming medical care. This characterization, even if it were accurate, which it is not, holds gender-affirming medical care for



adolescents with gender dysphoria to an inappropriately high standard, a standard that many accepted medical treatments do not attain.

4. The legislative findings also mischaracterize the potential benefits and risks of gender-affirming medical care to treat gender dysphoria and fail to demonstrate why the decision to undergo such treatment should uniquely be removed from adolescents, their parents or guardians, and their healthcare professionals. The legislation again establishes a double standard between permitted and prohibited treatment.

5. As a result, HB 1570 puts clinicians in the untenable position of either following state law and not providing essential treatment, or facing professional discipline, including permanent revocation of their licenses. Either outcome results in harm to patients.

6. I have actual knowledge of the matters stated in this declaration. In preparing this declaration, I reviewed the materials listed in the attached Bibliography (Exhibit B) as well as the relevant legislation. I may rely on those documents as additional support for my opinions. I have also relied on my years of research and other experience, as set out in my curriculum vitae (Exhibit A), and on the materials listed therein. The materials I have relied upon in preparing this declaration are the same types of materials that experts in medicine and bioethics regularly rely upon when forming opinions on the subject. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications, or in response to statements and issues that may arise in my area of expertise.

#### **BACKGROUND AND QUALIFICATIONS**

7. I am the Director of the Ethics Center, the Lee Ault Carter Chair of Pediatric Ethics, and an Attending Physician in the Division of Hospital Medicine at Cincinnati Children's

Hospital Medical Center (“Cincinnati Children’s”). I am also a Professor in the Departments of Pediatrics and Surgery at the University of Cincinnati College of Medicine.

8. I received my medical degree from Washington University School of Medicine in St. Louis, Missouri in 2000. I received my PhD in Religious Ethics from The University of Chicago Divinity School in 2000. I completed my Pediatrics residency at the University of Utah in 2003.

9. I have been licensed to practice medicine since 2001 and am currently licensed to practice medicine in Ohio. I have been Board Certified in General Pediatrics since 2004 and in Pediatric Hospital Medicine since the inception of this certification in 2019. I have been certified as a Healthcare Ethics Consultant since the inception of this certification in 2019.

10. I have extensive experience as a pediatrician and as a bioethicist. I have been in clinical practice since 2003 and 30% of my current effort is dedicated to caring for hospitalized patients. I was Chair of the Ethics Committee at Primary Children’s Medical Center in Salt Lake City, Utah from 2005 to 2012 and have been Director of the Ethics Center at Cincinnati Children’s since 2012. I regularly consult on cases at the Transgender Health Clinic at Cincinnati Children’s and participate in the Clinic’s monthly multidisciplinary team meetings. I am also part of Cincinnati Children’s team that cares for patients born with intersex traits, also known as differences or disorders of sex development (DSD). I am also the Chair of Cincinnati Children’s Fetal Care Center’s Oversight Committee which provides the Center recommendations on the use of innovative treatments and experimental interventions.

11. I am a member of the American Academy of Pediatrics, the American Society for Bioethics and Humanities, the Association of Bioethics Program Directors, and the Society for Pediatric Research. I was a member of the American Academy of Pediatrics Committee on

Bioethics from 2005 to 2011 and am currently the Associate Editor of the Ethics Rounds section of the Academy's lead journal *Pediatrics*. I have also served as a member of the American Society for Bioethics and Humanities' Clinical Ethics Consultation Affairs Committee from 2009 to 2014 and currently serve on its Healthcare Ethics Consultant Certification Commission.

12. I am the author of 37 peer-reviewed journal articles, 11 non-peer-reviewed journal articles, 6 book chapters, and 25 commentaries. My peer-reviewed journal articles have been published in high-impact journals including the *Journal of the American Medical Association* and *Annals of Internal Medicine*. I am also an author of 17 policy statements and technical reports, including 4 as lead author, by the American Academy of Pediatrics.

13. I have not previously testified as an expert in either deposition or at trial. I am being compensated at an hourly rate of \$250 per hour for preparation of expert declarations and reports, and \$400 per hour for time spent preparing for or giving deposition or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

## **BACKGROUND ON MEDICAL DECISION-MAKING IN PEDIATRICS**

### **Research and evidence**

14. Clinical practice and research or experimentation are distinguished by their goals and methods. Clinical practice's goal is to benefit individual patients and its method is individualized decision-making. Research's goal is to contribute to generalizable knowledge and research is conducted using formal protocols that describe its objective and procedures. New or innovative medical interventions are not research or experimentation by virtue of being innovative. They should, however, eventually be the object of research to evaluate their safety and efficacy. See National Commission for the Protection of Human Subjects of Biomedical and

Behavioral Research. *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. [Bethesda, MD]: The Commission; 1978.

15. The method of evaluation of new or innovative medical interventions depends in part on the nature of the intervention; new medications have a different evaluation process than new surgical techniques. See U.S. Food and & Administration. Development & approval process | Drugs. October 28, 2019. Available at <https://www.fda.gov/drugs/development-approval-process-drugs>. Accessed June 7, 2021 and Hirst A, Philippou Y, Blazeby J, et al. No surgical innovation without evaluation: Evolution and further development of the IDEAL Framework and recommendations. *Ann Surg*. 2019;269(2):211-220.

16. A variety of study designs are used to evaluate innovations. They include observational studies, which include cross-sectional and longitudinal studies, and randomized trials. In cross-sectional studies, investigators collect data at a single point in time. Cross-sectional design permits investigators to examine potential associations between factors, but it cannot prove one factor caused the other. In longitudinal studies, researchers follow particular individuals over time, making continuous or repeated measures. In a randomized trial, participants are randomly assigned to a treatment or a comparison group. The major benefit of a randomized trial is that it decreases the likelihood that any differences in the outcomes between the groups is the result of baseline differences between the groups rather than the result of the intervention. Each of these study designs have their strengths and weaknesses and selecting among them depends on a variety of factors including the study question, ethical considerations, feasibility, and cost. See Guyatt G, Rennie D, Meade MO, et al., eds. *Users' Guide to the Medical Literature: A Manual for Evidence-Based Clinical Practice*. 3rd ed. McGraw Hill

Education; 2015 and Perry-Parrish C, Dodge R. Research and statistics: validity hierarchy for study design and study type. *Pediatr Rev.* 2010;31(1):27-29.

17. The diffusion of innovation in health care is a complex process. Many innovations fail to diffuse and are not widely adopted. Factors that influence diffusion include competing or complementary innovations, the innovation's benefits and detriments, influential members of the social system's behavior, and potential adopters' innovativeness. See Dearing JW, Cox JG. Diffusion of innovations theory, principles, and practice. *Health Aff (Millwood)*. 2018;37(2):183-190. Some have described adoption as occurring in waves or phases: clinical study, leading practice, majority adoption, and general access. Following clinical study, the practice may spread to and then beyond a limited group of pioneering institutions. It may eventually reach underserved communities. See Balas EA, Chapman WW. Road map for diffusion of innovation in health care. *Health Aff (Millwood)*. 2018;37(2):198-204.

18. Given the increasing size of the medical literature, finding useful information to inform decision-making may be difficult. The optimal resource, if it is available, is a summary or guideline. See Guyatt G, Rennie D, Meade MO, et al., eds. *Users' Guide to the Medical Literature: A Manual for Evidence-Based Clinical Practice*. 3rd ed. McGraw Hill Education; 2015. Guidelines, often published by professional associations, are developed using systematic processes to select and review scientific evidence. Guidelines typically rate the quality of the evidence and grade the strength of recommendations. See American Academy of Pediatrics Steering Committee on Quality Improvement and Management. Classifying recommendations for clinical practice guidelines. *Pediatrics*. 2004;114(3):874-877 and Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490.

Guidelines can facilitate the majority adoption of a practice. See Balas EA, Chapman WW. Road map for diffusion of innovation in health care. *Health Aff* (Millwood). 2018;37(2):198-204.

19. The quality of evidence is “the extent to which one can be confident that an estimate of effect is correct (Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490).” The quality of evidence is based on four factors: study design, study quality, consistency, and directness. With respect to study design, randomized trials generally provide “high” quality evidence and observational studies, in comparison, “low.” There are, however, times when randomized trials are not feasible and instances in which observational studies provide higher quality evidence than randomized trials. Furthermore, the quality of studies’ methods and execution, consistency in outcomes across studies, and similarity between the people, interventions, and outcomes in the study and in clinical practice—also called directness—should be considered. Limitations in quality, consistency, and directness may result in randomized trials moving from “high” to “moderate” or “low” levels of evidence. See Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490.

20. When making recommendations, the authors of guidelines consider whether the intervention in question does more good than harm. The quality of the evidence is only one factor considered in making recommendations. Other considerations include the baseline risk in the population, the trade-offs between the benefits and harms, and differences between the research and actual practice. “Moderate” or “low” quality evidence may be sufficient to make a recommendation. See Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490.

21. In the field of pediatrics, parents or guardians and their children must often make decisions about medical care without the benefit of randomized trials. Clinical research focusing on children is less likely to use randomized trials than is clinical research for adults. Potential reasons for this disparity include the low prevalence of childhood disease, small market share for therapeutic agents in children, low level of National Institutes of Health funding, and difficulty enrolling children in research. See Martinez-Castaldi C, Silverstein M, Baucher H. Child versus adult research: The gap in high-quality study design. *Pediatrics*. 2008;122(1):52-57.

22. In addition, it may, at times, be unethical to conduct randomized trials. For randomized trials to be ethical, clinical equipoise must exist; there must be uncertainty about whether the efficacy of the intervention or the control is greater. Otherwise, it would be unethical to knowingly expose trial participants to an inferior intervention or control. Trials must also be feasible; it would also be unethical to expose individuals to the risks of trial participation without the benefit of the trial generating generalizable knowledge. A randomized trial that is unlikely to find enough people to participate because they believe they might be randomized to an inferior intervention would be unethical because it could not produce generalizable knowledge due to an inadequate sample size. See Emanuel EJ, Wendler D, Grady C. What makes clinical research ethical? *JAMA*. 2000;283(20):2701-2711.

### **Principles of informed consent and shared decision-making in pediatric medicine**

23. As a general matter, when deciding on a particular course of treatment, patients and their healthcare providers should participate in a shared decision-making process, in which they discuss scientific evidence, and the patient's own values, goals, and preferences. See Kon AA, Morrison W. Shared decision-making in pediatric practice: A broad view. *Pediatrics*. 2018;142(Suppl 3):S129-S132. Within this framework, healthcare providers should recommend

treatments when their potential benefits outweigh their risks and they are likely to promote the patient's values, preferences, and goals, and they should recommend against treatments when their potential risks outweigh their benefits and they are likely to frustrate achieving the patient's values, preferences, and goals. In cases in which the risks and benefits are relatively balanced or the evaluation of the risks and benefits is highly contingent on individual's preferences, the provider may describe the benefits, risks, and alternatives without making a recommendation. The decision ultimately rests with the patient.

24. Shared decision-making in pediatrics is more complex than in adult medicine because it involves both minor patients and their parents or guardians. Parents and guardians are afforded substantial, but not unlimited, discretion in making medical decisions for their minor children based on their assessment of the individual child's best interest. They, for example, generally care about their children and best understand their children's unique needs. See Diekema DS. Parental refusals of medical treatment: the harm principle as threshold for state intervention. *Theor Med Bioeth.* 2004;25(4):243-264.

25. Healthcare providers also have an ethical obligation to include children in medical decision-making to the extent that it is developmentally appropriate. For example, a provider examining a toddler for a possible ear infection should not ask a toddler for permission to look in the child's ear, but the provider could ask the toddler which ear the child would like to have looked in first. As a minor becomes older, the minor should participate more actively in shared decision-making. In early adolescence, individuals typically have developed a sense of identity, individual values and preferences, and are developing medical decision-making capacity. Capacity entails the ability to (i) understand the indications and the potential benefits, risks, and alternatives to a treatment, including declining treatment; (ii) appreciate the implications of a

treatment decision for their own lives; (iii) evaluate the potential benefits and risks; and (iv) express a preference. See Katz AL, Webb SA, Committee on Bioethics. Informed consent in decision-making in pediatric practice. *Pediatrics*. 2016;138(2) and Kon AA, Morrison W. Shared decision-making in pediatric practice: A broad view. *Pediatrics*. 2018;142(Suppl 3):S129-S132.

26. I am unaware of any instances—apart from the Arkansas statute at issue in this case—in which the government categorically prohibits minors and their parents or guardians from accessing treatment supported by evidence of efficacy.

27. State action in medical decision-making for minors is usually a positive intervention to provide medical care to a minor following a parent’s refusal to consent to recommended treatment and, even then, such decisions are exceptional and highly individualized. For example, a court may order a blood transfusion for a child over parental objections if the child would die or be seriously disabled without a transfusion or another intervention that a transfusion would enable. See Jenny C, Committee on Child Abuse and Neglect, American Academy of Pediatrics. Recognizing and responding to medical neglect. *Pediatrics*. 2007;120(6):1385-1389.

**ARKANSAS’S STATED REASONS FOR PROHIBITING TREATMENT RELATED TO GENDER TRANSITION FOR MINORS**

28. The legislative findings in HB 1570 do not provide a sound medical or ethical basis for outlawing the provision of gender-affirming medical care for adolescents with gender dysphoria. The state’s criticisms of gender-affirming medical care for minors mischaracterize the evidence base for gender-affirming medical treatment, are contrary to generally accepted principles of medical ethics, and would also apply to many other well-accepted medical treatments.

**Asserted lack of adequate medical research supporting the banned medical care**

29. Although the act is entitled the “Arkansas Save Adolescents from Experimentation (SAFE) Act,” adolescents with gender dysphoria are not being subject to research or experimentation; they are being provided clinical care directed toward their best interests and based on individualized decision-making.

30. The General Assembly’s findings in HB 1570 suggest that there is inadequate evidence to support the prevailing paradigm for the treatment of adolescents with gender dysphoria. They specifically cite a lack of “long-term longitudinal studies” on puberty blocking drugs and a lack of “randomized clinical trials” of cross-sex hormone therapy. As discussed above, study design is not the sole factor to be considered in rating the quality of evidence or grading the strength of recommendations. Therefore, even if the legislature’s assertions were correct, they would not provide a sound justification for a blanket ban on the prevailing medical protocols for the treatment of adolescents with gender dysphoria. In any case, the legislature mischaracterizes the evidence.

31. The Endocrine Society, an international medical organization of over 18,000 endocrinology researchers and clinicians, has published a clinical practice guideline for the treatment of gender-dysphoric/gender-incongruent persons including pubertal suppression, sex hormone treatment, and surgery for gender confirmation. The guideline both rates the quality of the evidence and grades the strength of its recommendations. See Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2017;102(11):3869-3903. See also World Professional Association for Transgender Health. *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People.* 7th Version. 2012.

32. The Endocrine Society “suggest[s] that adolescents who meet diagnostic criteria for GD [gender dysphoria]/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development (Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2017;102(11):3871).” The evidence for this recommendation includes a longitudinal study of a cohort of 70 transgender adolescents who were evaluated using objective measures prior to both pubertal suppression and sex hormone treatment. The mean length of time between the start of pubertal suppression and sex hormone treatment was 1.88 years and ranged from 0.42 to 5.06 years. The study showed statistically significant decreases in behavioral and emotional problems and depressive symptoms, and increases in general functioning. See de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med.* 2011;8(8):2276-2283.

33. Cohen-Kettenis and colleagues have also published longitudinal studies on the physical effects of pubertal suppression. See Delemarre-van de Waal HA, Cohen-Kettenis PT. Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. *Eur J Endocrinol.* 2006;155(suppl 1):S131–S137 and Schagen SE, Cohen-Kettenis PT, Delemarre-van de Waal HA, Hannema SE. Efficacy and safety of gonadotropin-releasing hormone agonist treatment to suppress puberty in gender dysphoric adolescents. *J Sex Med.* 2016;13(7):1125-1132.

34. Additional longitudinal studies of the psychosocial effects of pubertal suppression to treat gender dysphoria include Costa R, Dunsford M, Skagerberg E, Holt V, Carmichael P, Colizzi M. Psychological support, puberty suppression, and psychosocial functioning in

adolescents with gender dysphoria. *J Sex Med.* 2015;12(11):2206-2214 and Carmichael P, Butler G, Masic U, et al. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLoS One.* 2021;16(2):e0243894.

35. There are, therefore, longitudinal studies evaluating the risks and benefits of pubertal suppression for the treatment of gender dysphoria. The cited studies are of appropriate duration given puberty suppression is only intended to occur between the first physical changes of puberty, and confirmation of the persistence of gender dysphoria/gender incongruence and development of the individual's capacity to give informed consent to hormone therapy. See Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2017;102(11):3871. Cohen-Kettenis and colleagues have conducted longer-term follow-up of individuals through sex hormone and gender-affirming surgical treatment. Participants' mean age at their initial assessment was 13.6 year and their mean age at their final assessment was 20.7 years. See de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics.* 2014;134(4):696-704.

36. In addition, contrary to the General Assembly's findings in HB 1570, there are randomized clinical trials to evaluate the efficacy and safety of sex hormone treatment for gender dysphoria. Pelusi and colleagues randomized transgender men (individuals assigned female at birth who identify as male) to one of 3 different testosterone formulations. They evaluated anthropometric, metabolic, bone, hematological, and biochemical parameters at baseline and after 12 months of treatment. See Pelusi C, Costantino A, Martelli V, et al. Effects of three

different testosterone formulations in female-to-male transsexual persons. *J Sex Med.* 2014;11(12):3002-3011.

37. While such comparative effectiveness trials (trials comparing different, established pharmacological treatments to one another) should continue, randomized, placebo-controlled trials (trials that compare pharmacological treatment to no pharmacological treatment) in gender dysphoria are currently unethical. Potential investigators do not have equipoise between pharmacological treatment and no pharmacological treatment; they believe that pharmacological treatment is superior. It is also highly unlikely that a sufficient number of participants would enroll in randomized controlled trials for them to be informative. See Chew D, Anderson J, Williams K, May T, Pang K. Hormonal treatment in young people with gender dysphoria: A systematic review. *Pediatrics.* 2018;141(4) and Reisner SL, Deutsch MB, Bhasin S, et al. Advancing methods for US transgender health research. *Curr Opin Endocrinol Diabetes Obes.* 2016;23(2):198-207.

38. Even if such studies could be conducted ethically, they would provide a lower quality of evidence because of intrinsic limitations in their design. For example, it would be impossible to blind the investigators or the participants to whether the participants were receiving the active treatment or a placebo. They would know if they were in the intervention or other control arm of the study due to the physical changes in their bodies, or the lack thereof, over time.

39. While attempting to support HB1570 by asserting a lack of randomized controlled trials, the law permits other treatments that also lack such evidence. The law permits the use of gonadotropin-releasing hormone (GnRH) agonists, colloquially called puberty blockers, to treat central precocious puberty because the treatment is not performed for the purpose of affirming a

gender identity different from a minor's sex assigned at birth. Central precocious puberty is the premature initiation of puberty, before 8 years of age in people assigned female at birth and before 9 in people assigned male, by the central nervous system. Its negative effects include impairment of final adult height as well as antisocial behavior and lower academic achievement.

40. There are no randomized trials evaluating the adult height of treated and untreated individuals. Most studies are observational and compare pretreatment predicted final height with actual final height. These studies have additional limitations including small sample sizes. This "low quality" evidence nonetheless is sufficiently strong to support the use of GnRH agonists as treatment for central precocious puberty. See Mul D, Hughes IA. The use of GnRH agonists in precocious puberty. *Eur J Endocrinol.* 2008;159 Suppl 1:S3-8.

41. HB 1570's therefore subjects the use of puberty blockers to a double standard. There are no randomized clinical trials for the use of puberty blockers to treat precocious puberty or gender dysphoria, but the evidence is deemed sufficient for the former but not the latter.

**Asserted interest in protecting "vulnerable children" from the risks of gender-affirming medical care**

42. The legislative findings of HB 1570 indicate that it is intended to protect the health and safety of "vulnerable" children and that "the risks of gender transition procedures far outweigh any benefit at this stage of clinical study on these procedures." The legislative findings neglect the risks of inadequately treated gender dysphoria, and the benefits of gender-affirming medical care. They also fail to provide evidence for why, for just this one type of medical care, the legislature's evaluation of the potential benefits and risks is to be preferred to that of adolescents, their parents or guardians, and healthcare professionals.

43. Transgender individuals experience significant risks to their well-being. They have higher rates of depression, anxiety, suicidal ideation, and suicide attempts. See, for

example, Haas AP, Eliason M, Mays VM, et al. Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations. *J Homosex*. 2011;58(1):10-51.

Contributing factors include conflict between one's appearance and identity, stigma, and rejection. See Bauer GR, Scheim AI, Pyne J, Travers R, Hammond R. Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada. *BMC Public Health*. 2015;15:525.

44. The potential benefits of gender-affirming medical care include improved physical and psychological outcomes. Starting pubertal suppression in early puberty prevents the development of undesirable secondary sex characteristic which may be difficult, if not impossible, to eliminate. Sex hormone therapy permits the development of secondary sex characteristics consistent with individuals' gender identity. Potential psychological benefits include increased quality of life and decreased depression, suicidal ideation and suicide attempts, and anxiety. See, for example, Baker KE, Wilson LM, Sharma R, Dukhanin V, McArthur K, Robinson KA. Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review. *J Endocr Soc*. 2021;5(4):bvab011. For some transgender adolescents, gender-affirming medical care is lifesaving.

45. For many transgender individuals, the potential benefits of gender-affirming medical care substantially outweigh the risks. In addition to the Endocrine Society's and World Professional Association for Transgender Health's guidelines, see Rafferty J, Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence, et al. Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*. 2018;142(4) and American Psychiatric Association. Position statement on treatment of transgender (trans) and gender diverse youth. 2020. Weighing the potential benefits and risks

of the treatment for gender dysphoria is a prudential judgment similar to other judgments made by adolescent patients and their parents or guardians as part of general ethical principles of shared decision-making. Indeed, adolescent patients and their parents or guardians often make decisions about treatments with less evidence and/or greater risks than gender-affirming care.

46. The current treatment paradigm for treating gender dysphoria in minors is consistent with general ethical principles instantiated in the practices of informed consent and shared decision-making. The Endocrine Society clinical practice guideline extensively discusses the potential benefits, risks, and alternatives to treatment, and its recommendations regarding the timing of interventions are based in part on the treatment's potential risks and the adolescent's decision-making capacity. The guidelines recommend that informed consent for pubertal blockers and sex hormones include a discussion of the implications for fertility and options for fertility preservation. The Endocrine Society clinical guideline also advises delaying gender-affirming hormone treatment, which results in partly irreversible physical changes, until an adolescent is capable of consenting. While the guideline suggests delaying gender-affirming genital surgery involving removal of the testes, ovaries, and/or uterus until the patient is at least 18 years old, it states clinicians should individualize decision-making for breast or chest surgery in transgender males (individuals assigned female at birth who identify as male) and that chest surgery may be considered in individuals under 18 years old. See Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2017;102(11):3869-3903.

47. While HB 1570 would prohibit chest surgery to treat transgender males, minors are permitted to undergo many comparable surgeries, such as those for gynecomastia, pectus

excavatum or carinatum, and breast reconstruction. Gynecomastia is the proliferation of ductal or glandular breast tissue, as opposed to adipose tissue or fat, in individuals assigned male at birth. Pectus excavatum and carinatum are chest wall anomalies in which the sternum is depressed or protrudes, respectively. While surgeries to treat these conditions, as well as breast reduction and augmentation for individuals assigned female at birth who identify as female, may at times be performed to lessen physical symptoms, such as pain or exercise intolerance, they are commonly performed to reduce psychosocial distress. Risks include bleeding, infection, scarring and poor cosmetic outcome, loss of sensation, and impaired breast/chest feeding. Some surgeries have unique risks such as catastrophic perforations of the heart or lungs in some forms of pectus repair, or capsule formation around a breast implant causing hardening and pain. See Buziashvili D, Gopman JM, Weissler H, et al. An evidence-based approach to management of pectus excavatum and carinatum. *Ann Plast Surg.* 2019;82(3):352-358, Nordt CA, DiVasta AD. Gynecomastia in adolescents. *Curr Opin Pediatr.* 2008;20(4):375-382, and Zuckerman D, Abraham A. Teenagers and cosmetic surgery: Focus on breast augmentation and liposuction. *J Adolesc Health.* 2008;43(4):318-324.

48. As these examples of chest surgeries in adolescence illustrate, surgeries for minors can require weighing short- and long-term effects and benefits and risks in the face of uncertainty. Individuals' values and beliefs shape these evaluations and, therefore, the adolescents' participation is essential. There is nothing unique about chest surgery for gender dysphoria that justifies singling out this and similar procedures for prohibition based on the risk-benefit ratio, or concern for adolescents' inability to assent or parents or guardians' inability to consent. Medical decisions regarding treatment for gender dysphoria should continue to be left to

the discretion of transgender adolescents, their parents or guardians, and their healthcare professionals.

49. Ironically, at the same time that HB 1570 prohibits gender-affirming medical care for minors in the name of protecting vulnerable children, the statute expressly allows doctors to perform irreversible genital surgeries on infants and children with intersex conditions or differences or disorders in sexual development (DSD) at ages when they are unable to meaningfully participate in medical decision-making. The evidence base for these surgeries is poor and they are highly controversial when performed at such an early age. See Jesus LE. Feminizing genioplasties: Where are we now? *J Pediatr Urol.* 2018;14(5):407-415 and Frader J, Alderson P, Asch A, et al. Health care professionals and intersex conditions. *Arch Pediatr Adolesc Med.* 2004;158(5):426-428. This double standard is difficult to explain.

### CONCLUSION

50. Treating adolescents with gender dysphoria with pubertal suppression, sex hormones, and chest surgery under clinical practice guidelines, like the Endocrine Society's, is sufficiently evidence-based and its benefits and risks are well within the range of other medical decisions that adolescents and their parents or guardians have the discretion to make in consultation with their healthcare professionals.

51. Based on my research and experience as a pediatrician and bioethicist, there is no sound medical or ethical basis to prohibit healthcare professionals from providing gender-affirming medical care to minors or referring their patients to other doctors to receive this care. Doing so puts clinicians in the untenable position of having to either follow state law or risk losing their licenses; either outcome harms their patients.

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

Executed on JUNE 11, 2021



ARMAND H. MATHENY AN TOMM MARIA, MD, PhD

**EXHIBIT A**  
**Curriculum Vitae**

Last Updated: June 11, 2021

**PERSONAL DATA**

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**EDUCATION**

1983-1987	BSEE	Valparaiso University, with High Distinction Valparaiso, IN
1983-1987	BS	Valparaiso University (Chemistry), with High Distinction Valparaiso, IN
1987-1989	MD	Washington University School of Medicine Saint Louis, MO
1989-2000	PhD	The University of Chicago Divinity School (Religious Ethics) Chicago, IL
2000-2003	Resident	University of Utah (Pediatrics) Salt Lake City, UT
2005-2006	Certificate	Conflict Resolution Certificate Program, University of Utah Salt Lake City, UT

**BOARD CERTIFICATION**

2019	Pediatric Hospital Medicine, American Board of Pediatrics
2019	Healthcare Ethics Consultant-Certified, Healthcare Ethics Consultation Certification Commission
2004	General Pediatrics, American Board of Pediatrics

**PROFESSIONAL LICENSES**

2012-Present	Doctor of Medicine, Ohio
2006-2010	Alternative Dispute Resolution Provider—Mediator, Utah
2001-2014	Physician and Surgeon, Utah
2001-2014	Physician and Surgeon Controlled Substance, Utah

**PROFESSIONAL EXPERIENCE**

**Full Time Positions**

2019-Present	<i>Professor</i> Cincinnati Children's Hospital Medical Center, Cincinnati, OH Department of Surgery
2019-Present	<i>Professor of Clinical-Affiliated</i> University of Cincinnati, Cincinnati, OH Department of Surgery
2017-Present	<i>Professor</i> Cincinnati Children's Hospital Medical Center, Cincinnati, OH Division of Pediatric Hospital Medicine

2017-Present *Professor of Clinical-Affiliated*  
 University of Cincinnati, Cincinnati, OH  
 Department of Pediatrics

2016-2017 *Associate Professor of Clinical-Affiliated*  
 University of Cincinnati, Cincinnati, OH  
 Department of Pediatrics

2012-2017 *Associate Professor*  
 Cincinnati Children’s Hospital Medical Center, Cincinnati, OH  
 Division of Pediatric Hospital Medicine

2012-Present *Lee Ault Carter Chair in Pediatric Ethics*  
 Cincinnati Children’s Hospital Medical Center

2012-2016 *Associate Professor-Affiliated*  
 University of Cincinnati, Cincinnati, OH  
 Department of Pediatrics

2010-2012 *Associate Professor of Pediatrics (with Tenure)*  
 University of Utah School of Medicine, Salt Lake City, UT  
 Divisions of Inpatient Medicine and Medical Ethics

2010-2012 *Adjunct Associate Professor of Medicine*  
 University of Utah School of Medicine, Salt Lake City, UT  
 Division of Medical Ethics and Humanities

2004-2010 *Assistant Professor of Pediatrics (Tenure Track)*  
 University of Utah School of Medicine, Salt Lake City, UT  
 Divisions of Inpatient Medicine and Medical Ethics

2004-2010 *Adjunct Assistant Professor of Medicine*  
 University of Utah School of Medicine, Salt Lake City, UT  
 Division of Medical Ethics and Humanities

2003-2004 *Instructor of Pediatrics (Clinical Track)*  
 University of Utah School of Medicine, Salt Lake City, UT  
 Divisions of Inpatient Medicine and Medical Ethics

2003-2004 *Adjunct Instructor of Medicine*  
 University of Utah School of Medicine, Salt Lake City, UT  
 Division of Medical Ethics

**Part Time Positions**

2021 *Expert Witness*  
 Dylan Brandt, et al., v. Leslie Rutledge, et al., Civil Action Case No. 4:21CV450-JM

2019 *Consultant*  
 Sanofi Genzyme, Cambridge, MA

2018-Present *Consultant*  
 Center for Conflict Resolution in Healthcare, Memphis, TN

2017-2020 *Consultant*  
 Amicus Therapeutics, Cranbury, NJ

2017 *Expert Witness*  
 Robert J. Klickovich, MD, PLLC v. Tristate Arthritis & Rheumatology, PSC, et al.,  
 Commonwealth of Kentucky, Boone Circuit Court, Division III, Civil Action No. 16-CI-  
 01690

2017 *Consultant*  
 Sarepta Therapeutics, Cambridge, MA

2014 *Consultant*  
 Genzyme, A Sanofi Company, Cambridge, MA

**Editorial Experience**

## Editorial Board

- 2020-Present *Pediatrics*, Associate Editor for Ethics Rounds and Member of the Executive Editorial Board
- 2015-2020 *Journal of Clinical Ethics*
- 2009-2020 *Journal of Medical Humanities*

## Guest Academic Editor

- 2017 *PLOS/ONE*

Ad Hoc Reviewer: *Academic Medicine, Academic Pediatrics, AJOB Primary Research, American Journal of Bioethics, American Journal of Medical Genetics, American Journal of Transplantation, BMC Medical Ethics, BMJ Open, Canadian Journal of Bioethics, Clinical Transplantation, European Journal of Human Genetics, Frontiers in Genetics, Hospital Medicine, International Journal of Health Policy and Management, International Journal of Nursing Studies, Journal of Adolescent and Young Adult Oncology, Journal of Clinical Ethics, Journal of Empirical Research on Human Research Ethics, Journal of General Internal Medicine, Journal of Healthcare Leadership, Journal of Hospital Medicine, Journal of the Kennedy Institute of Ethics, Journal of Law, Medicine & Ethics, Journal of Medical Ethics, Journal of Medical Humanities, Journal of Medicine and Life, Journal of Palliative Care, Journal of Pediatrics, Journal of Pediatric Surgery, Mayo Clinic Proceedings, Medicine, Healthcare and Philosophy, Molecular Diagnosis & Therapy, New England Journal of Medicine, Patient Preference and Adherence, Pediatrics, Pediatrics in Review, Personalized Medicine, PLOS/ONE, Risk Management and Healthcare Policy, Saudi Medical Journal, and Theoretical Medicine and Bioethics*

**SCHOLASTIC AND PROFESSIONAL HONORS**

- 2021 *Hidden Gem Award*, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
- 2019 *Presidential Citation*, American Society for Bioethics and Humanities, Chicago, IL
- 2016 *Laura Mirkinson, MD, FAAP Lecturer*, Section on Hospital Medicine, American Academy of Pediatrics, Elk Grove Village, IL
- 2016, 2018 *Certificate of Excellence*, American Society for Bioethics and Humanities, Glenview, IL
- 2013, 2016 *Senior Resident Division Teaching Award*, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
- 2012 *Role Model*, Quality Review Committee, Primary Children's Medical Center, Salt Lake City, UT
- 2011 *Member*, Society for Pediatric Research, The Woodlands, TX
- 2011, 2020 *Presidential Citation Award*, American Society for Bioethics and Humanities, Glenview, IL
- 2009 *Role Model*, Quality Review Committee, Primary Children's Medical Center, Salt Lake City, UT
- 2008 *Nominee*, Physician of the Year, Primary Children's Medical Center, Salt Lake City, UT
- 2005-2006 *Fellow*, Medical Scholars Program, University of Utah School of Medicine, Salt Lake City, UT
- 1995-1997 *Doctoral Scholar*, Crossroads, A Program of Evangelicals for Social Action, Philadelphia PA
- 1989-1992 *Fellow*, The Pew Program in Medicine, Arts, and the Social Sciences, University of Chicago, Chicago, IL

**ADMINISTRATIVE EXPERIENCE****Administrative Duties**

2019-Present *Chair*, Oversight Committee, Cincinnati Fetal Center, Cincinnati, OH  
 2014-Present *Chair*, Ethics Committee, Cincinnati Children's Hospital Medical Center, Cincinnati, OH  
 2012-Present *Director*, Ethics Center, Cincinnati Children's Hospital Medical Center, Cincinnati, OH  
 2012-Present *Chair*, Ethics Consultation Subcommittee, Cincinnati Children's Hospital Medical Center, Cincinnati, OH  
 2010 *Co-Chair*, Ethics Subcommittee, Work Group for Emergency Mass Critical Care in Pediatrics, Centers for Disease Control and Prevention, Atlanta, GA  
 2009 *Chair*, Ethics Working Group, H1N1 and Winter Surge, Primary Children's Medical Center, Salt Lake City, UT  
 2005-2012 *Chair*, Ethics Committee, Primary Children's Medical Center, Salt Lake City, UT  
 2005-2012 *Chair*, Ethics Consultation Subcommittee, Primary Children's Medical Center, Salt Lake City, UT  
 2003-4 *Chair*, Clinical Pertinence Committee, Primary Children's Medical Center, Salt Lake City, UT

**Professional & Scientific Committees**

## Committees

2021 *Member*, EMCO Capacity Collaboration, Ohio Hospital Association, Columbus, OH  
 2020-2021 *Member*, Allocation of Scarce Resources Work Group, Ohio Hospital Association, Columbus, OH  
 2020-Present *Member*, Literature Selection Technical Review Committee, National Library of Medicine, Bethesda, MD  
 2020 *Member*, Crisis Standards of Care Workgroup, The Health Collaborative, Cincinnati, OH  
 2019-Present *Member*, Healthcare Ethics Consultant Certification Commission, Oak Park, IL  
 2019 *Member*, Expert Panel, Pediatric Oncology End-of-Life Care Quality Markers, Institute for Cancer Outcomes & Survivorship, University of Alabama at Birmingham, Birmingham, AL  
 2018 *Member*, Resource Planning and Allocation Team Implementation Task Force, Ohio Department of Health, Columbus, OH  
 2012-Present *Member*, Gaucher Initiative Medical Expert Committee, Project HOPE, Millwood, VA  
 2009-2014 *Member*, Clinical Ethics Consultation Affairs Committee, American Society for Bioethics and Humanities, Glenview, IL  
 2005-2011 *Member*, Committee on Bioethics, American Academy of Pediatrics, Oak Park, IL

## Data Safety and Monitoring Boards

2019-Present *Member*, Data and Safety Monitoring Board, Sickle Cell Domestic Trials, National Heart, Lung, and Blood Institute, Bethesda, MD  
 2018-Present *Member*, Standing Safety Committee for P-188-NF (Carmeseal-MD™) in Duchenne Muscular Dystrophy, Phrixus Pharmaceuticals, Inc., Ann Arbor, MI  
 2017-Present *Member*, Observational Study Monitoring Board, Sickle Cell Disease Observational Monitoring Board, National Heart, Lung, and Blood Institute, Bethesda, MD  
 2016-2018 *Member*, Observational Study Monitoring Board, Long Term Effects of Hydroxyurea in Children with Sickle Cell Anemia, National Heart, Lung, and Blood Institute, Bethesda, MD

## Reviewer

2020-Present *Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting  
 2020 *Grant Reviewer*, The Croatian Science Foundation, Hrvatska zaklada za znanost (HRZZ)  
 2018 *Book Proposal Reviewer*, Elsevier

2018-2019 *Category Leader*, Religion, Culture, and Social Sciences, American Society for Bioethics and Humanities Annual Meeting

2017 *Timekeeper*, American Society for Bioethics and Humanities Annual Meeting

2017-Present *Abstract Reviewer*, Pediatric Academic Societies Annual Meeting

2016-Present *Workshop Reviewer*, Pediatric Academic Societies Annual Meeting

2016 *Grant Reviewer*, Innovation Research Incentives Scheme, The Netherlands Organisation for Health Research and Development

2016-2017 *Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting

2014, 2016 *External Peer Reviewer*, PSI Foundation, Toronto, Ontario, Canada

2014 *Member*, Scientific Committee, International Conference on Clinical Ethics and Consultation

2013 *Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting

2013 *Reviewer*, Open Research Area Plus, Agence Nationale de la Recherche, Deutsche Forschungsgemeinschaft, Economic and Social Research Council, National Science Foundation, and Organization for Scientific Research

2011-2012 *Abstract Reviewer*, Pediatric Academic Societies Annual Meeting

2011-2013 *Workshop Reviewer*, Pediatric Academic Societies Annual Meeting

2011-Present *Abstract Reviewer*, Pediatric Hospital Medicine Annual Meeting

2011-2012 *Religious Studies Subcommittee Leader*, Program Committee, American Society for Bioethics and Humanities Annual Meeting

2010 *Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting

Other

2109 *Mentor*, Early Career Advising Program, American Society for Bioethics and Humanities

2018 *Passing Point Determination*, Healthcare Ethics Consultant-Certified Examination, Healthcare Ethics Consultant Certification Commission

2018 *Member*, Examination Committee, Healthcare Ethics Consultant-Certified Examination, Healthcare Ethics Consultant Certification Commission

2018 *Item Writer*, Healthcare Ethics Consultant-Certified Examination, Healthcare Ethics Consultant Certification Commission

### **UNIVERSITY COMMUNITY ACTIVITIES**

#### **Cincinnati Children's Hospital Medical Center**

2020-Present *Member*, Faculty Diversity and Inclusion Steering Committee

2020-Present *Member*, Caregiver Refusal Team

2020-Present *Member*, COVID-19 Vaccine Allocation Committee

2020-Present *Member*, Medical Management of COVID-19 Committee

2020 *Member*, Personal Protective Equipment Subcommittee of the COVID-19 Steering Committee

2018-2019 *Member*, Planning Committee, Center for Clinical & Translational Science & Training Research Ethics Conference

2017 *Member*, Root Cause Analysis Team

2017-2020 *Member*, Employee Emergency Fund Review Committee

2016-2017 *Member*, Planning Committee, Center for Clinical & Translational Science & Training Research Ethics Conference

2015-2019 *Member*, Destination Excellence Medical Advisory Committee

2015-Present *Member*, Disorders of Sexual Development Case Review Committee

2015-2019 *Member*, Destination Excellence Case Review Committee

2014-2018 *Member*, Genomics Review Group, Institutional Review Board

2014-2017 *Member*, Center for Pediatric Genomics Leadership Committee

2013-2017 *Member*, Genetic Testing Subcommittee, Health Network

2013-2016 *Member*, Schwartz Center Rounds Planning Committee  
2013-2014 *Member*, Genomics Ad Hoc Subcommittee, Board of Directors  
2012-Present *Member*, Cincinnati Fetal Center Oversight Committee  
2012-Present *Member*, Ethics Committee  
2012-Present *Member*, G-23  
2012-2016 *Member*, Integrated Solid Organ Transplant Steering Committee

**University of Utah**

2009-2012 *Member*, Consolidated Hearing Committee

**University of Utah School of Medicine**

2010-2012 *Member*, Medical Ethics, Humanities, and Cultural Competence Thread Committee  
2008-2010 *Member*, Fourth Year Curriculum Committee

**University of Utah Department of Pediatrics**

2010-2011 *Member*, Planning Committee, 25<sup>th</sup> Annual Biological Basis of Children's Health Conference, "Sex, Gender, and Sexuality"  
2009-2012 *Member*, Medical Executive Committee  
2005-2012 *Member*, Retention, Promotion, and Tenure Committee  
2004-2012 *Interviewer*, Residency Program  
2003-2012 *Member*, Education Committee

**Intermountain Healthcare**

2009-2012 *Member*, System-Wide Bioethics Resource Service  
2009-2012 *Member*, Pediatric Guidance Council

**Primary Children's Medical Center**

2012-2012 *Member*, Shared Accountability Organization Steering Committee  
2009 *Member*, H1N1 and Winter Surge Executive Planning Team  
2005-2010 *Member*, Continuing Medical Education Committee  
2005-2010 *Member*, Grand Rounds Planning Committee  
2003-2012 *Member*, Ethics Committee

**ACTIVE MEMBERSHIPS IN PROFESSIONAL SOCIETIES**

2012-Present Association of Bioethics Program Directors  
2011-Present Society for Pediatric Research  
2000-Present American Academy of Pediatrics  
1999-Present American Society of Bioethics and Humanities

**FUNDING**

**Past Grants**

2015-2019 "Better Outcomes for Children: Promoting Excellence in Healthcare Genomics to Inform Policy."  
Percent Effort: 9%  
National Human Genome Research Institute  
Grant Number: 1U01 HG008666-01  
Role: Investigator

- 2015-2016 “Ethics of Informed Consent for Youth in Foster Care”  
Direct Costs: \$10,000  
Ethics Grant, Center for Clinical and Translational Science and Training  
University of Cincinnati Academic Health Center  
Role: Co-Investigator
- 2014-2015 “Extreme Personal Exposure Biomarker Levels: Engaging Community Physicians and  
Ethicists for Guidance”  
Direct Costs: \$11,640  
Center for Environmental Genetics  
University of Cincinnati College of Medicine  
Role: Investigator
- 2014-2015 “Child, Adolescent, and Parent Opinions on Disclosure Policies for Incidental Findings in  
Clinical Whole Exome Sequencing”  
Direct Costs: \$4,434  
Ethics Grant, Center for Clinical and Translational Science and Training, University of  
Cincinnati Academic Health Center  
Role: Principal Investigator
- 2013-2014 “Better Outcomes for Children: GWAS & PheWAS in eMERGEII  
Percent Effort: 5%  
National Human Genome Research Institute  
Grant Number: 3U01HG006828-0251  
Role: Investigator
- 2004-2005 "Potential Patients' Knowledge, Attitudes, and Beliefs Regarding Participating in  
Medical Education: Can They be Interpreted in Terms of Presumed Consent?"  
Direct Costs: \$8,000  
Interdisciplinary Research in Applied Ethics and Human Values, University Research  
Committee, University of Utah  
Role: Principal Investigator

## **TEACHING RESPONSIBILITIES/ASSIGNMENTS**

### **Course and Curriculum Development**

- 2003-2012 Medical Ethics, Internal Medicine 7560, University of Utah School of Medicine, Taught  
1 time per year, Taken by medical students, Enrollment 100

### **Course Lectures**

- 2018-Present Biomedical Ethics, “Conscientious Objection in Healthcare” and “Ethical Issues in the  
Care of Transgender Adolescents,” MEDS 4035 & MEDS 4036, University of Cincinnati  
College of Medicine, Taught 1 time per year, Taken by senior undergraduate students,  
Enrollment 52.
- 2016 Foundations of Healthcare Ethics and Law, “Clinical Ethics,” HESA 390, Xavier  
University.
- 2014-Present Physicians and Society, “Transfusion and the Jehovah’s Witness Faith,” “Obesity  
Management: Ethics, Policy, and Physician Implicit Bias,” “Embryos and Ethics: The  
Ethics of Designer Babies,” “Ethics and Genetic Testing,” and “Ethics and Direct to  
Consumer Genetic Testing,” 26950112 and 26950116, University of Cincinnati School of  
Medicine, Taken by first and second year medical students, Enrollment 100.
- 2014-Present Ethical Issues in Health Care, “Ethical Issues in Managing Drug Shortages: The Macro,

- Meso, and Micro Levels,” HESA 583, College of Social Sciences, Health, and Education Health Services Administration, Xavier University, Taken by health services administration students, Enrollment 25.
- 2009 Physical Diagnosis II, Internal Medicine 7160, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100
- 2003-2012 Medical Ethics, Internal Medicine 7560, University of Utah School of Medicine, Taught 1 time per year, Taken by fourth year medical students, Enrollment 100

### **Small Group Teaching**

- 2018-Present Ethics in Research, GNTD 7003-001, University of Cincinnati School of Medicine, Taught 1 time per year, Taken by fellows, MS, and PhD students, Enrollment 110.
- 2007 Physical Diagnosis I, Internal Medicine 7150, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100
- 2003-2012 Medical Ethics, Internal Medicine 7560, University of Utah School of Medicine, Taught 1 time per year, Taken by fourth medical students, Enrollment 100
- 2003 Pediatric Organ System, Pediatrics 7020, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100

### **Graduate Student Committees**

- 2018-Present *Chair*, Scholarship Oversight Committee, William Sveen, Pediatric Critical Care Fellowship, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH
- 2018-2020 *Member*, Scholarship Oversight Committee, Anne Heueman, Genetic Counseling, University of Cincinnati, Cincinnati, OH
- 2017-2019 *Chair*, Scholarship Oversight Committee, Bryana Rivers, Genetic Counseling, University of Cincinnati, Cincinnati, OH
- 2013-2015 *Mentor*, Sophia Hufnagel, Combined Pediatrics/Genetics Residency, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH
- 2013-2015 *Co-Chair*, Scholarship Oversight Committee, Andrea Murad, Genetic Counseling, University of Cincinnati, Cincinnati, OH
- 2013-2014 *Member*, Scholarship Oversight Committee, Grace Tran, Genetic Counseling, University of Cincinnati, Cincinnati, OH
- 2011-2012 *Chair*, Scholarship Oversight Committee, Kevin E. Nelson, MD, PhD, Pediatric Inpatient Medicine Fellowship, University of Utah, Salt Lake City, UT

### **Continuing Education Lectures**

- 2008 Choosing Healthplans All Together (CHAT) Exercise Facilitator, 18<sup>th</sup> Annual Intermountain Medical Ethics Conference, “Setting Priorities for Healthcare in Utah: What Choices are We Ready to Make?,” Salt Lake City, Utah, October 3.
- 2007 *Speaker*, Infant Medical Surgical Unit, Primary Children’s Medical Center, “Withholding and Withdrawing Artificial Nutrition and Hydration: Can It Be Consistent With Care?,” Salt Lake City, Utah, September 6.
- 2007 *Faculty Scholar-in Residence*, Summer Seminar, “The Role of Religion in Bioethics,” Utah Valley State College, Orem, Utah, May 1.
- 2006 *Workshop Leader*, Faculty Education Retreat, “Publications and Publishing in Medical Education,” University of Utah School of Medicine, Salt Lake City, Utah, September 15.
- 2006 *Breakout Session*, 16<sup>th</sup> Annual Intermountain Medical Ethics Conference, “Donation after Cardiac Death: Evolution of a Policy,” Salt Lake City, Utah, March 28.

**Other Educational Activities**

- 2008 *Instructor*, Contemporary Ethical Issues in Medicine and Medical Research, Osher Lifelong Learning Institute, University of Utah, “Religion and Bioethics: Religiously Based Demands for and Refusals of Treatment,” Salt Lake City, Utah, February 7.
- 2007 *Speaker*, Biology Seminar, Utah Valley State College, “Is He Dead?: Criteria of the Determination of Death and Their Implications for Withdrawing Treatment and Recovering Organs for Transplant,” Orem, Utah, September 21.

**PEER-REVIEWED JOURNAL ARTICLES**

1. Armand H. Matheny Antommara and Ndidi I. Unaka. (2021) “Counterpoint: Prioritizing Health Care Workers for Scarce Critical Care Resources is Impractical and Unjust.” *Journal of Hospital Medicine*. 16: 182-3. PMID 33617445.
2. Gregory A. Grabowski, Armand H. Matheny Antommara, Edwin H. Kolodny, and Pramod K. Mistry. (2021) “Gaucher Disease: Basic and Translational Science Needs for More Complete Therapy and Management.” *Molecular Genetics and Metabolism*. 132: 59-75. PMID: 33419694.
3. Armand H. Matheny Antommara, Laura Monhollen, and Joshua K. Schaffzin. (2021) “An Ethical Analysis of Hospital Visitor Restrictions and Masking Requirements During the COVID-19.” *Journal of Clinical Ethics*. 32(1): 35-44. PMID 33416516.
4. Armand H. Matheny Antommara (2020) “The Pediatric Hospital Medicine Core Competencies: 4.05 Ethics.” *Journal of Hospital Medicine*. 15(S1): 120-121.
5. Armand H. Matheny Antommara, Tyler S. Gibb, Amy L. McGuire, Paul Root Wolpe, Matthew K. Wynia, Megan K. Applewhite, Arthur Caplan, Douglas S. Diekema, D. Micah Hester, Lisa Soleymani Lehmann, Renee McLeod-Sordjan, Tamar Schiff, Holly K. Tabor, Sarah E. Wieten, and Jason T. Eberl for a Task Force of the Association of Bioethics Program Directors (2020) “Ventilator Triage Policies During the COVID-19 Pandemic at U.S. Hospitals Associated With Members of the Association of Bioethics Program Directors.” *Annals of Internal Medicine*. 173(3): 188-194. PMID: 32330224.
6. Armand H. Matheny Antommara (2020) “Conflicting Duties and Reciprocal Obligations During a Pandemic.” *Journal of Hospital Medicine*. 5:284-286. PMID: 32379030.
7. Mary V. Greiner, Sarah J. Beal, and Armand H. Matheny Antommara (2020) “Perspectives on Informed Consent Practices for Minimal-Risk Research Involving Foster Youth.” *Pediatrics*. 45:e20192845. PMID: 32156772.
8. Jennifer deSante-Bertkau, Michelle McGowan, and Armand H. Matheny Antommara (2018) “Systematic Review of Typologies Used to Characterize Clinical Ethics Consultations.” *Journal of Clinical Ethics*. 29:291-304. PMID: 30605439.
9. Andrew J. Redmann, Melissa Schopper, Armand H. Matheny Antommara, Judith Ragsdale, Alessandro de Alarcon, Michael J. Jutter, Catherine K. Hart, and Charles M. Myer. (2018) “To Transfuse or Not to Transfuse? Jehovah’s Witnesses and PostOperative Hemorrhage in Pediatric Otolaryngology.” *International Journal of Pediatric Otorhinolaryngology*. 115:188-192. PMID: 30368384.
10. Armand H. Matheny Antommara, Kyle B. Brothers, John A. Myers, Yana B Feygin, Sharon A. Aufox, Murray H. Brilliant, Pat Conway, Stephanie M. Fullerton, Nanibaa’ A. Garrison, Carol R. Horowitz, Gail P. Jarvik, Rongling Li, Evette J. Ludman, Catherine A. McCarty, Jennifer B. McCormick, Nathaniel D. Mercaldo, Melanie F. Myers, Saskia C. Sanderson, Martha J. Shrubsole, Jonathan S. Schildcrout, Janet L. Williams, Maureen E. Smith, Ellen Wright Clayton, Ingrid A. Holm. (2018) “Parents’ Attitudes toward Consent and Data Sharing in Biobanks: A Multi-Site Experimental Survey.” *AJOB Empirical Research*. 21:1-15. PMID: 30240342.
11. Armand H. Matheny Antommara and Cynthia A. Prows. (2018) “Content Analysis of Requests for Religious Exemptions from a Mandatory Influenza Vaccination Program for Healthcare Personnel” *Journal of Medical Ethics*. 44: 389-391. PMID: 29463693.

12. Armand H. Matheny Antommara (2017) “May Medical Centers Give Nonresident Patients Priority in Scheduling Outpatient Follow-Up Appointments?” *Journal of Clinical Ethics*. 28: 217-221. PMID: 28930708.
13. Andrea M. Murad, Melanie F. Myers, Susan D. Thompson, Rachel Fisher, and Armand H. Matheny Antommara (2017) “A Qualitative Study of Adolescents’ Understanding of Biobanks and Their Attitudes Toward Participation, Re-contact, and Data Sharing.” *American Journal of Medical Genetics: Part A*. 173: 930-937. PMID: 28328120.
14. Saskia Sanderson, Kyle Borthers, Nathaniel Mercaldo, Ellen Wright Clayton, Armand Antommara, Sharon Aufox, Murray Brilliant, Diego Campos, David Carrell, John Connolly, Pat Conway, Stephanie Fullerton, Nanibaa Garrison, Carol Horowitz, Gail Jarvik, David Kaufman, Terrie Kitchner, Rongling Li, Evette Ludman, Catherine McCarty, Jennifer McCormick, Valerie McManus, Melanie Myers, Aaron Scrol, Janet Williams, Martha Shrubsole, Jonathan Schildcrout, Maureen Smith, and Ingrid Holm (2017) “Public Attitudes Towards Consent and Data Sharing in Biobank Research: A Large Multisite Experimental Survey in the US.” *The American Journal of Human Genetics*. 100: 414-427. PMID: 28190457.
15. Maureen E. Smith, Saskia C Sanderson, Kyle B Brothers, Melanie F Myers, Jennifer McCormick, Sharon A Aufox, Martha J Shrubsole, Nanibaa’ A Garrison, Nathaniel D Mercaldo, Jonathan S Schildcrout, Ellen Wright Clayton, Armand H. Matheny Antommara, Melissa Basford, Murray Brilliant, John J Connolly, Stephanie M Fullerton, Carol R Horowitz, Gail P Jarvik, Dave Kaufman, Terrie Kitchner, Rongling Li, Evette J Ludman, Catherine McCarty, Valerie McManus, Sarah C Stallings, Janet L Williams, and Ingrid A Holm (2016) “Conducting a Large, Multi-Site Survey about Patients’ Views on Broad Consent: Challenges and Solutions.” *BMC Medical Research Methodology*. 16: 162. PMID: 27881091.
16. Angela Lorts, Thomas D. Ryan, Armand H. Matheny Antommara, Michael Lake, and John Bucuvalas (2016) “Obtaining Consensus Regarding International Transplantation Continues to be Difficult for Pediatric Centers in the United States.” *Pediatric Transplant*. 20: 774-777. PMID: 27477950.
17. Sophia B. Hufnagel, Lisa J. Martin, Amy Cassidy, Robert J. Hopkin, and Armand H. Matheny Antommara (2016) “Adolescents’ Preferences Regarding Disclosure of Incidental Findings in Genomic Sequencing That Are Not Medically Actionable in Childhood.” *American Journal of Medical Genetics Part A*. 170: 2083-2088. PMID: 27149544.
18. Nanibaa’ A. Garrison, Nila A. Sathe, Armand H. Matheny Antommara, Ingrid A. Holm, Saskia Sanderson, Maureen E. Smith, Melissa McPheeters, and Ellen Wright Clayton (2016) “A Systematic Literature Review of Individuals’ Perspectives on Broad Consent and Data Sharing in the United States.” *Genetics in Medicine*. 18: 663-71. PMID: 26583683.
19. Kyle B. Brothers, Ingrid A. Holm Janet E. Childerhose, Armand H. Matheny Antommara, Barbara A. Bernhardt, Ellen Wright Clayton, Bruce D. Gelb, Steven Joffe, John A. Lynch, Jennifer B. McCormick, Laurence B. McCullough, D. William Parsons, Agnes S. Sundaresan, Wendy A. Wolf, Joon-Ho Yu, and Benjamin S. Wilfond (2016) “When Genomic Research Participants Grow Up: Contact and Consent at the Age of Majority.” *The Journal of Pediatrics* 168: 226-31. PMID: 26477867.
20. Erin E. Bennett, Jill Sweney, Cecile Aguayo, Criag Myrick, Armand H. Matheny Antommara, and Susan L. Bratton (2015) “Pediatric Organ Donation Potential at a Children’s Hospital.” *Pediatric Critical Care Medicine*. 16: 814-820. PMID: 26237656.
21. Anita J. Tarzian, Lucia D. Wocial, and the ASBH Clinical Ethics Consultation Affairs Committee (2015) “A Code of Ethics for Health Care Ethics Consultants: Journey to the Present and Implications for the Field.” *American Journal of Bioethics*. 15: 38-51. PMID: 25970392.
22. Armand H. Matheny Antommara, Christopher A. Collura, Ryan M. Antiel, and John D. Lantos (2015) “Two Infants, Same Prognosis, Different Parental Preferences.” *Pediatrics*, 135: 918-923. PMID: 25847802.

23. Stefanie Benoit, Armand H. Matheny Antommaria, Norbert Weidner, and Angela Lorts (2015) “Difficult Decision: What should we do when a VAD supported child experiences a severe stroke?” *Pediatric Transplantation* 19: 139-43. PMID: 25557132.
24. Kyle B. Brothers, John A. Lynch, Sharon A. Aufox, John J. Connolly, Bruce D. Gelb, Ingrid A. Holm, Saskia C. Sanderson, Jennifer B. McCormick, Janet L. Williams, Wendy A. Wolf, Armand H. Matheny Antommaria, and Ellen W. Clayton (2014) “Practical Guidance on Informed Consent for Pediatric Participants in a Biorepository.” *Mayo Clinic Proceedings*, 89: 1471-80. PMID: 25264176.
25. Sophia M. Bous Hufnagel and Armand H. Matheny Antommaria (2014) “Laboratory Policies on Reporting Secondary Findings in Clinical Whole Exome Sequencing: Initial Uptake of the ACMG’s Recommendations.” *American Journal of Medical Genetics Part A*, 164: 1328-31. PMID: 24458369.
26. Wylie Burke, Armand H. Matheny Antommaria, Robin Bennett, Jeffrey Botkin, Ellen Wright Clayton, Gail E. Henderson, Ingrid A. Holm, Gail P. Jarvik, Muin J. Khoury, Bartha Maria Knoppers, Nancy A. Press, Lainie Friedman Ross, Mark A. Rothstein, Howard Saal, Wendy R. Uhlmann, Benjamin Wilfond, Susan M. Wold, and Ron Zimmern (2013) “Recommendations for Returning Genomic Incidental Findings? We Need to Talk!” *Genetics in Medicine*, 15: 854-859. PMID: 23907645.
27. Armand H. Matheny Antommaria (2013) “An Ethical Analysis of Mandatory Influenza Vaccination of Health Care Personnel: Implementing Fairly and Balancing Benefits and Burdens,” *American Journal of Bioethics*, 13: 30-37. PMID: 23952830.
28. Joseph A. Carrese and the Members of the American Society for Bioethics and Humanities Clinical Ethics Consultation Affairs Standing Committee (2012) “HCEC Pearls and Pitfalls: Suggested Do’s and Don’t’s for Healthcare Ethics Consultants,” *Journal of Clinical Ethics*, 23: 234-240. PMID: 23256404.
29. Christopher G Maloney, Armand H Matheny Antommaria, James F Bale Jr., Jian Ying, Tom Greene and Rajendu Srivastava (2012) “Factors Associated with Intern Noncompliance with the 2003 Accreditation Council for Graduate Medical Education's 30-hour Duty Period Requirement,” *BMC Medical Education* 12: 33. PMID: 22621439.
30. Armand H. Matheny Antommaria, Jill Sweney, and W. Bradley Poss (2010) “Critical Appraisal of: Triageing Pediatric Critical Care Resources During a Pandemic: Ethical and Medical Considerations,” *Pediatric Critical Care Medicine*, 11:396-400. PMID: 20453611.
31. Armand H. Matheny Antommaria, Karen Trotochaud, Kathy Kinlaw, Paul N. Hopkins, and Joel Frader (2009) “Policies on Donation After Cardiac Death at Children’s Hospitals: A Mixed-Methods Analysis of Variation,” *Journal of the American Medical Association*, 301: 1902-8. PMID: 19436017.
32. Kristine M. Pleacher, Elizabeth S. Roach, Willem Van der Werf, Armand H. Matheny Antommaria, and Susan L. Bratton (2009) “Impact of a Pediatric Donation after Cardiac Death Program,” *Pediatric Critical Care Medicine*, 10: 166-70. PMID: 19188881.
33. Flory L. Nkoy, Sarah Petersen, Armand H Matheny Antommaria, and Christopher G. Maloney (2008) “Validation of an Electronic System for Recording Medical Student Patient Encounters,” *AMIA [American Medical Informatics Association] Annual Symposium Proceedings*, 6: 510-14. PMID: 18999155. Nominated for the Distinguished Paper Award
34. Armand H. Matheny Antommaria, Sean D. Firth, and Christopher G. Maloney (2007) “The Evaluation of an Innovative Pediatric Clerkship Structure Using Multiple Outcome Variables including Career Choice” *Journal of Hospital Medicine*, 2: 401-408. PMID: 18081170.
35. Armand H. Matheny Antommaria (2006) “‘Who Should Survive?: One of the Choices on Our Conscience:’ Mental Retardation and the History of Contemporary Bioethics.” *Kennedy Institute of Ethics Journal*, 16: 205-224. PMID: 17091558.
36. Armand H. Matheny Antommaria (2004) “Do as I Say Not as I Do: Why Bioethicists Should Seek Informed Consent for Some Case Studies.” *Hastings Center Report*, 34 (3): 28-34. PMID: 15281724.
37. Armand H. Matheny Antommaria (2004) “A Gower Maneuver: The American Society for Bioethics and Humanities’ Resolution of the ‘Taking Stands’ Debate.” *American Journal of Bioethics*, 4 (Winter): W24-27. PMID: 15035934.

**NON PEER-REVIEWED JOURNAL ARTICLES**

1. Katherine Wade and Armand H. Matheny Antommara (2016) "Inducing HIV Remission in Neonates: Children's Rights and Research Ethics." *Journal of Medicine and Biology*, 58(3): 348-54. PMID 27157354.
2. Armand H. Matheny Antommara (2014) "Response to Open Peer Commentaries on 'An Ethical Analysis of Mandatory Influenza.'" *American Journal of Bioethics*, 14(7): W1-4. PMID: 24978422.
3. Armand H. Matheny Antommara and Brent D. Kaziny (2012) "Ethical Issues in Pediatric Emergency Medicine's Preparation for and Response to Disasters." *Virtual Mentor*, 14: 801-4. PMID: 23351860.
4. Armand H. Matheny Antommara, Tia Powell, Jennifer E. Miller, and Michael D. Christian (2011) "Ethical Issues in Pediatric Emergency Mass Critical Care," *Pediatric Critical Care Medicine*, 12(6 Suppl): S163-8. PMID: 22067926.
5. Armand H. Matheny Antommara and Emily A. Thorell (2011) "Non-Pharmaceutical Interventions to Limit Transmission of a Pandemic Virus: The Need for Complementary Programs to Address Children's Diverse Needs." *Journal of Clinical Ethics*, 22: 25-32. PMID: 21595352.
6. Armand H. Matheny Antommara (2010) "Conscientious Objection in Clinical Practice: Notice, Informed Consent, Referral, and Emergency Treatment." *Ave Maria Law Review*, 9: 81-99.
7. Armand H. Matheny Antommara (2008) "Defending Positions or Identifying Interests: The Uses of Ethical Argumentation in the Debate over Conscience in Clinical Practice," *Theoretical Medicine and Bioethics*, 29: 201-12. PMID: 18821078.
8. Armand H. Matheny Antommara (2008) "How can I give her IV antibiotics at home when I have three other children to care for?: Using Dispute System Design to Address Patient-Provider Conflicts in Health Care." *Hamline Journal of Public Law & Policy*, 29: 273-86.
9. Armand H. Matheny Antommara (2007) "Alternative Dispute Resolution and Pediatric Clinical Ethics Consultation: Why the Limits of Ethical Expertise and the Indeterminacy of the Best Interests Standard Favor Mediation." *Ohio State Journal on Dispute Resolution*, 23: 17-59.
10. Armand H. Matheny Antommara (2006) "Jehovah's Witnesses, Roman Catholicism, and Calvinism: Religion and State Intervention in Parental, Medical Decision-Making," *Journal of Law and Family Studies*, 8: 293-316.
11. Armand H. Matheny Antommara and James F. Bale, Jr. (2002) "Ethical Issues in Clinical Practice: Cases and Analyses," *Seminars in Pediatric Neurology* 9: 67-76. PMID: 11931129.

**REVIEW ARTICLES**

Armand H. Matheny Antommara (2010) "Conceptual and Ethical Issues in the Declaration of Death: Current Consensus and Controversies." *Pediatrics in Review* 31: 427-430. PMID: 20889737.

**BOOKS**

Armand H. Matheny Antommara (1998) *A Retrospective, Political and Ethical Analysis of State Intervention into Parental Healthcare Decisions for Infants with Disabilities*. Wynnewood, Pennsylvania: Evangelicals for Social Action.

**BOOK CHAPTERS**

1. Armand H. Matheny Antommara (2018) "Against Medical Advice Discharges: Pediatric Considerations." In *Against-Medical-Advice Discharges from the Hospital: Optimizing Prevention and Management to Promote High-Quality, Patient-Centered Care*. David Alfandre. New York, Springer: 143-157.
2. Armand H. Matheny Antommara (2016) "Conscientious Objection in Reproductive Medicine." In *The Oxford Handbook of Reproductive Ethics*. Leslie Francis. Oxford, Oxford University Press: 209-225.

3. Armand H. Matheny Antommara (2011) "Patient Participation in Medical Education." In *Clinical Ethics in Pediatrics: A Case-based Approach*. Douglas Diekema, Mark Mercurio, and Mary Beth Adam. Cambridge, Cambridge University Press: 221-225.
4. Armand H. Matheny Antommara (2011) "State Intervention in Parental Decision Making: *Gone Baby Gone*." In *The Picture of Health: Medical Ethics and the Movies*. Henri Colt, Silvia Quadrelli, and Lester Friedman. Oxford, Oxford University Press: 308-12.
5. Armand H. Matheny Antommara (2009) "Managing Conflicts of Interest: A Perspective from a Pediatrician." In *Professionalism in Medicine: The Case-Based Guide for Medical Students*. John Spandorfer, Charles Pohl, Thomas Nasca and Susan Lee Rattner. Cambridge, Cambridge University Press: 376-7.
6. Armand H. Matheny Antommara (2007) "Do-Not-Resuscitate Orders." In *Comprehensive Pediatric Hospital Medicine*. L. B. Zaoutis and V. W. Chiang. Philadelphia, Mosby Elsevier: 1200-4.

## **OTHER**

### **Policy Statements and Technical Reports**

1. American Academy of Pediatrics Committee on Bioethics. Armand H. Matheny Antommara Lead Author. (2013) "Conflicts between Religious or Spiritual Beliefs and Pediatric Care: Informed Refusal, Exemptions, and Public Funding." *Pediatrics*. 132: 962-965. PMID: 24167167.
2. American Academy of Pediatrics Committee on Bioethics. Armand H. Matheny Antommara Lead Author. (2013) "Ethical Controversies in Organ Donation After Circulatory Death." *Pediatrics*. 131: 1021-1026. PMID: 23629612.
3. American Academy of Pediatrics Committee on Bioethics and Committee on Genetics and the American College of Medical Genetics and Genomics Social, Ethical, and Legal Issues Committee (2013) "Policy Statement: Ethical and Policy Issues in Genetic Testing and Screening of Children." *Pediatrics*. 131: 620-622. PMID: 23428972.
4. Lainie Friedman Ross, Howard M. Saal, Karen L. David, Rebecca R. Anderson and the American Academy of Pediatrics Committee on Bioethics and Committee on Genetics and the American College of Medical Genetics and Genomics Social, Ethical, and Legal Issues Committee (2013) "Technical Report: Ethical and Policy Issues in Genetic Testing and Screening of Children." *Genetics in Medicine*. 15: 234-245. PMID: 23429433.
5. American Academy of Pediatrics Committee for Pediatric Research and Committee on Bioethics (2012) "Human Embryonic Stem Cell (hESC) and Human Embryo Research." *Pediatrics* 130: 972-977. PMID: 23109685.
6. American College of Obstetricians and Gynecologists, Committee on Ethics and American Academy of Pediatrics, Committee on Bioethics (2011) "Maternal-Fetal Intervention and Fetal Care Centers," *Pediatrics* 128; e473-e478. PMID: 21788223.
7. American Academy of Pediatrics Committee on Pediatric Emergency Medicine and Committee on Bioethics (2011) "Consent for Emergency Medical Services for Children and Adolescents." *Pediatrics* 128: 427-433. PMID: 21788221.
8. Council on School Health and Committee on Bioethics. Robert Murray and Armand H. Matheny Antommara Lead Authors. (2010) "Honoring –Do-Not-Attempt Resuscitation Requests in Schools." *Pediatrics* 125; 1073-1077. PMID: 20421255.
9. Committee on Bioethics (2010) "Ritual Genital Cutting of Female Minors." *Pediatrics* 125; 1088-1093. PMID: 20421257.
10. Committee on Bioethics. (2010) "Children as Hematopoietic Stem Cell Donors," *Pediatrics* 125; 392-40. PMID: 20100753.
11. Committee on Bioethics. Armand H. Matheny Antommara Lead Author. (2009) "Physician Refusal to Provide Information or Treatment Based on Claims of Conscience." *Pediatrics*. 124; 1689-93. PMID: 19948636.
12. Committee on Bioethics (2009) "Pediatrician-Family-Patient Relationships: Managing the Boundaries." *Pediatrics* 124; 1685-8. PMID: 19948635.

13. Douglas S. Diekema, Jeffrey R. Botkin, and Committee on Bioethics (2009) “Forgoing Medically Provided Nutrition and Hydration in Children.” *Pediatrics* 124; 813-22. PMID: 19651596.
14. Lainie Friedman Ross, J. Richard Thistlethwaite, Jr., and the Committee on Bioethics (2008) “Minors as Living Solid-Organ Donors.” *Pediatrics* 122: 454-61. PMID: 18676567.
15. Mary E. Fallat, John Hutter, and Section on Hematology Oncology and Section on Surgery the Committee on Bioethics (2008) “Preservation of Fertility in Pediatric and Adolescent Patients with Cancer.” *Pediatrics* 121: 1461-9. PMID: 18450888.
16. Marcia Levetown and Bioethics and the Committee on Bioethics (2008) “Communicating With Children and Families: From Everyday Interactions to Skill in Conveying Distressing Information.” *Pediatrics* 121: 1441-60. PMID: 18450887.
17. American Academy of Pediatrics. Committee on Bioethics (2007) “Professionalism in Pediatrics: Statement of Principles.” *Pediatrics* 120:895-7. PMID: 17908776.

### **Ethics Rounds**

1. Natalie Lanocha, Tyler Tate, Erica Salter, Nanette Elster, and Armand H. Matheny Antommara. (2021) “Can Parents Restruct Access to Their Adolescent’s Voice?: Deciding About a Tracheostomy.” *Pediatrics*. 147: e2021050358. PMID 33785636.
2. Timothy Crisci, Zeynep N. Inanc Salih, Ndidi Unaka, Jehanna Peerzada, and Armand H. Matheny Antommara. (2021) “What Should an Intern Do When She Disagrees With the Attending?” *Pediatrics*. 147: e2020049646. PMID 33627371.
3. Liza-Marie Johnson, Erica C. Kaye, Kimberly Sawyer, Alex M. Brenner, Stefan J. Friedrichsdorf, Abby R. Rosenberg, Armand H. Matheny Antommara. (2021) “Opioid Management in the Dying Child With Addiction.” *Pediatrics* 147: e2020046219. PMID 33446508.

### **Continuing Medical Education**

1. Armand H. Matheny Antommara (2014) Authored 4 questions. NEJM Knowledge+ Family Medicine Board Review. NEJM Group.
2. Armand H. Matheny Antommara (2009) “Hot Topics: Ethics and Donation After Cardiac Death [online course]. PediaLink. American Academy of Pediatrics. October 24. <http://ethics.ht.courses.aap.org/>. Accessed December 14, 2009.

### **Editorials**

1. Armand H. Matheny Antommara, Chris Feudtner, Mary Beth Benner, and Felicia Cohn on Behalf of the Healthcare Ethics Consultant-Certified Certification Commission (2020) “The Healthcare Ethics Consultant-Certified Program: Fair, Feasible, and Defensible, But Neither Definite Nor Finished,” *American Journal of Bioethics* 20:1-5. PMID: 32105202.
2. Armand H. Matheny Antommara and Pamela W. Popp (2020) “The Potential Roles of Surrogacy Ladders, Standby Guardians, and Medicolegal Partnerships, in Surrogate Decision Making for Parents of Minor Children,” *Journal of Pediatrics* 220:11-13. PMID 31952849.

### **Commentaries**

1. William Sveen and Armand H. Matheny Antommara. (2020) “Why Healthcare Workers Should Not Be Prioritized in Ventilator Triage.” *American Journal of Bioethics*. 20(7): 133-135. PMID: 32716811.
2. Armand H. Matheny Antommara, William Sveen, and Erika L. Stalets (2020) “Informed Consent Should Not Be Required for Apnea Testing and Arguing It Should Misses the Point,” *American Journal of Bioethics*. 20: 25-27. PMID: 32441602.
3. Armand H. Matheny Antommara (2019) “Relational Potential versus the Parent-Child Relationship,” *Hastings Center Report*. 49(3): 26-27. PMID: 31269255.

4. Armand H. Matheny Antommara, Robert A. Shapiro, and Lee Ann E. Conard (2019) "Psychological Maltreatment and Medical Neglect of Transgender Adolescents: The Need for Recognition and Individualized Assessment." *American Journal of Bioethics*. 19: 72-74. PMID: 31543011.
5. Armand H. Matheny Antommara (2018) "Accepting Things at Face Value: Insurance Coverage for Transgender Healthcare." *American Journal of Bioethics*. 18: 21-23. PMID: 31159689.
6. Armand H. Matheny Antommara and Judith R. Ragsdale (2018) "Shaken, not Stirred: What are Ethicists Licensed to Do?" *American Journal of Bioethics* 18: 56-58. PMID: 29697345.
7. Armand H. Matheny Antommara (2017) "Issues of Fidelity and Trust Are Intrinsic to Uncontrolled Donation after Circulatory Determination of Death and Arise Again with Each New Resuscitation Method," *American Journal of Bioethics* 17: 20-22. PMID: 28430053.
8. Armand H. Matheny Antommara (2016) "Conscientious Objection: Widening the Temporal and Organizational Horizons," *The Journal of Clinical Ethics* 27: 248-250. PMID: 27658282.
9. Armand H. Matheny Antommara and Ron King. (2016) "Moral Hazard and Transparency in Pediatrics: A Different Problem Requiring a Different Solution." *American Journal of Bioethics* 16: 39-40. PMID: 27292846.
10. Armand H. Matheny Antommara and Richard F. Ittenabch (2016) "Quality Attestation's Portfolio Evaluation Is Feasible, But Is It Reliable and Valid?" *American Journal of Bioethics* 16: 35-38. PMID: 26913658.
11. Armand H. Matheny Antommara and Kristin Stanley Bramlage (2015) "Enrolling Research Participants in Private Practice: Conflicts of Interest, Consistency, Therapeutic Misconception, and Informed Consent." *AMA Journal of Ethics*. 17:1122-1126. PMID: 26698585.
12. Armand H. Matheny Antommara (2015) "Characterizing Clinical Ethics Consultations: The Need for a Standardized Typology of Cases." *American Journal of Bioethics* 15: 18-20. PMID: 25970383.
13. Armand H. Matheny Antommara (2015) "Intensified Conflict Instead of Closure: Clinical Ethics Consultants' Recommendations' Potential to Exacerbate Ethical Conflicts." *American Journal of Bioethics* 15: 52-4. PMID: 25562231.
14. Lainie Friedman Ross and Armand H. Matheny Antommara (2014) "The need to promote all pediatric stem cell donors' understanding and interests." *Pediatrics* 133: e1356-e1357. PMID: 24777208.
15. Armand H. Matheny Antommara (2014) "Pubertal Suppression and Professional Obligations: May a Pediatric Endocrinologist Refuse to Treat an Adolescent with Gender Dysphoria." *American Journal of Bioethics* 13: 43-46. PMID: 24422933.
16. Armand H. Matheny Antommara (2012) "Empowering, Teaching, and Occasionally Advocating: Clinical Ethics Consultants' Duties to All of the Participants in the Process." *American Journal of Bioethics* 12 11-3. PMID: 22852533.
17. Armand H. Matheny Antommara (2010) "Dying but not Killing: Donation after Cardiac Death Donors and the Recovery of Organs." *Journal of Clinical Ethics* 21: 229-31. PMID: 21089993.
18. Armand H. Matheny Antommara and Julie Melini (2010) "Is it Reasonable to Refuse to be Seen by a Nurse Practitioner in the Emergency Department?" *American Journal of Bioethics* 10: 15-17. PMID: 20694899.
19. William Meadow, Chris Feudtner, Armand H. Matheny Antommara, Dane Sommer, John Lantos (2010) "A Premature Baby with Necrotizing Enterocolitis Whose Parents Are Jehovah's Witnesses." *Pediatrics*. 216: 151-155. PMID: 20566607.
20. C. C. Weitzman, S. Schlegel, Nancy Murphy, Armand H. Matheny Antommara, J. P. Brosco, Martin T. Stein (2009) "When Clinicians and a Parent Disagree on the Extent of Medical Care." *Journal of Developmental and Behavioral Pediatrics*. 30: 242-3. PMID: 19525718. Reprinted as (2010) *Journal of Developmental and Behavioral Pediatrics*. 31: S92-5. PMID: 20414087
21. Armand H. Matheny Antommara and Susan Bratton (2008) "Nurses' Attitudes toward Donation after Cardiac Death: Implications for Nurses' Roles and Moral Distress." *Pediatric Critical Care Medicine*, 9: 339-40. PMID: 18446100.

22. Armand H. Matheny Antommara and Nannette\_C. Dudley (2007) "Should Families Be Present During CPR?" *AAP Grand Rounds*, 17: 4-5.
23. Armand H. Matheny Antommara (2006) "The Proper Scope of Analysis of Conscientious Objection in Healthcare: Individual Rights or Professional Obligations" *Teaching Ethics*, 7: 127-31.
24. Armand H. Matheny Antommara and Rajendu Srivastava (2006) "If Cardiologists Take Care of Patients with Heart Disease, What do Hospitalists Treat?: Hospitalists and the Doctor-Patient Relationship." *American Journal of Bioethics*, 6: 47-9. PMID: 16423793.
25. Armand H. Matheny Antommara (2003) "I Paid Out-of-Pocket for My Son's Circumcision at Happy Valley Tattoo and Piercing: Alternative Framings of the Debate over Routine Neonatal Male Circumcision," *American Journal of Bioethics* 3: 51-3. PMID: 12859817.

### Letters

1. Benjamin S. Wilfond, David Magnus, Armand H Matheny Antommara, Paul Appelbaum, Judy Aschner, Keith J. Barrington, Tom Beauchamp, Renee D. Boss, Wylie Burke, Arthur L. Caplan, Alexander M. Capron, Mildred Cho, Ellen Wright Clayton, F. Sessions Cole, Brian A. Darlow, Douglas Diekema, Ruth R. Faden, Chris Feudtner, Joseph J. Fins, Norman C. Fost, Joel Frader, D. Micah Hester, Annie Janvier, Steven Joffe, Jeffrey Kahn, Nancy E. Kass, Eric Kodish, John D. Lantos, Laurence McCullough, Ross McKinney, Jr., William Deadow, P. Pearl O'Rourke, Kathleen E. Powderly, DeWayne M. Pursley, Lainie Friedman Ross, Sadath Sayeed, Richard R. Sharp, Jeremy Sugarman, William O. Tarnow-Mordi, Holly Taylor, Tom Tomlison, Robert D. Truog, Yoram T. Unguru, Kathryn L. Weise, David Woodrum, Stuart Youngner (2013) "The OHRP and SUPPORT," *New England Journal of Medicine*, 368: e36. PMID: 23738513.
2. Lainie Friedman Ross and Armand H. Matheny Antommara (2011) "In Further Defense of the American Academy of Pediatrics Committee on Bioethics 'Children as Hematopoietic Stem Cell Donors' Statement." *Pediatric Blood & Cancer*. 57: 1088-9.
3. Armand H. Matheny Antommara (2011) "Growth Attenuation: Health Outcomes and Social Services." *Hastings Center Report*, 41(5): 4. PMID: 21980886.
4. Susan Bratton and Armand H. Matheny Antommara (2010) "Dead Donor Rule and Organ Procurement: The Authors Reply." *Pediatric Critical Care Medicine*, 11: 314-5.
5. Armand H. Matheny Antommara and Joel Frader (2009) "Policies of Children's Hospitals on Donation After Cardiac Death—Reply." *Journal of the American Medical Association*, 302: 845.

### Case Reports

Armand H. Matheny Antommara (2002) "Case 4.9: Inappropriate Access to a Celebrity's Medical Records." In *Ethics and Information Technology: A Case-Based Approach to a Health Care System in Transition*, James G. Anderson and Kenneth W. Goodman, 79-80. New York: Springer-Verlag.

### Book Reviews

1. Armand H. Matheny Antommara (2021) Review of *When Harry Became Sally: Responding to the Transgender Moment*, by Ryan T. Anderson. *Journal of Medical Humanities* 42: 195-9. PMID 31808021.
2. Armand H. Matheny Antommara (2012) Review of *The Ethics of Organ Transplantation*, by Steven J. Jensen, ed., *Journal of the American Medical Association* 308: 1482-3.
3. Armand H Matheny Antommara (2012) Review of *The Soul of Medicine: Spiritual Perspectives and Clinical Practice*, by John R. Peteet and Michael N. D'Ambra, ed., *Journal of the American Medical Association* 308: 87.
4. Armand H. Matheny Antommara (2009) Review of *Conflicts of Conscience in Health Care: An Institutional Compromise*, by Holly Fernandez Lynch. *American Journal of Bioethics* 9: 63-4.
5. Armand H. Matheny Antommara (2008) Review of *A Practical Guide to Clinical Ethics Consulting: Expertise, Ethos, and Power*, by Christopher Meyers. *American Journal of Bioethics* 8: 72-3.

6. Armand H. Matheny Antommaria (2004) Review of *Children, Ethics, and Modern Medicine*, by Richard B. Miller. *American Journal of Bioethics* 4: 127-8.
7. Armand H. Matheny Antommaria (2002) Review of *Ward Ethics: Dilemmas for Medical Students and Doctors in Training*, by Thomasine Kushner and David Thomasma, ed. *American Journal of Bioethics* 2: 70-1. PMID: 22494193.
8. Armand H. Matheny Antommaria (1999) Review of *Human Cloning: Religious Responses*, by Ronald Cole-Turner, ed. *Prism* 6 (March/April): 21.
9. Armand H. Matheny Antommaria (1999) Review of *Christian Theology and Medical Ethics: Four Contemporary Approaches*, by James B. Tubbs, Jr. *Journal of Religion* 79 (April): 333-5.
10. Armand H. Matheny Antommaria (1997) Review of *Body, Soul, and Bioethics*, by Gilbert C. Meilaender. *Prism* 4 (May/June): 28.

### **Newspaper Articles**

1. W. Bradley Poss and Armand H. Matheny Antommaria (2010) "Mass casualty planning must incorporate needs of children." *AAP News* 31 (July): 38.
2. Robert Murray and Armand H. Matheny Antommaria (2010) "Pediatricians should work with school nurses to develop action plans for children with DNAR orders." *AAP News* 31 (May): 30..
3. Armand H. Matheny Antommaria (2009) "Addressing physicians' conscientious objections in health care." *AAP News* 30 (December): 32.

### **UNPUBLISHED POSTER PRESENTATIONS**

1. Armand H. Matheny Antommaria. (2018) "Ethical Issues in the Care of International Patients: A Case Study." International Conference on Clinical Ethics and Consultation, Oxford, United Kingdom.
1. Jill S Sweney, Brad Poss, Colin Grissom, Brent Wallace, and Armand H Matheny Antommaria, (2010) "Development of a Statewide Pediatric Pandemic Triage Plan in Utah." Pediatric Academic Societies Annual Meeting, Vancouver, Canada. E-PAS20103713.147.
2. Christopher G. Maloney, Armand H. Matheny Antommaria, James F. Bale, Thomas Greene, Jian Ying, Gena Fletcher, and Rajendu Srivastava (2010) "Why Do Pediatric Interns Violate the 30 Hour Work Rule?" Pediatric Academic Societies Annual Meeting, Vancouver, Canada. E-PAS20101500.596
3. Armand H. Matheny Antommaria and Edward B. Clark (2007) "Resolving Conflict through Bioethics Mediation." 3<sup>rd</sup> International Conference on Ethics Consultation and Clinical Ethics, Toronto, Canada.
4. Elizabeth Tyson, Tracy Hill, Armand Antommaria, Gena Fletcher, and Flory Nkoy (2007) "Physician Practice Patterns Regarding Nasogastric Feeding Supplementation and Intravenous Fluids in Bronchiolitis Patients." Pediatrics Academic Societies Annual Meeting, Toronto, Canada. E-PAS2007:61300.

### **ORAL PRESENTATIONS**

#### **Keynote/Plenary Lectures**

##### International

1. 2021, *Moderator*, Partnership for Quality Medical Donations, Charitable Access Programming for Rare Diseases, "Ethical Issues," Webinar, April 6.
2. 2017, *Invited Speaker*, Spina Bifida Fetoscopic Repair Study Group and Consortium, "Ethics of Innovation and Research in Fetal Surgery," Cincinnati, Ohio, October 26.
3. 2014, *Invited Speaker*, CIC 2013 CCI: Canadian Immunization Conference, "Condition-of-Service Influenza Prevention in Health Care Settings," Ottawa, Canada, December 2.
4. 2014, *Invited Speaker*, National Conference of the Chinese Pediatric Society, "A Brief Introduction to Pediatric Research and Clinical Ethics," Chongqing, China, September 12.

National

1. 2020, *Panelist*, Children's Mercy Bioethics Center, "Ethical Issues in the COVID Pandemic at Children's Hospitals," Webinar, March 2.
2. 2019, *Invited Speaker*, North American Fetal Therapy Network (NAFTnet), "Ethics of Innovation," Chicago, Illinois, October 12.
3. 2019, *Panelist*, National Society of Genetic Counselors Prenatal Special Interest Group, "Fetal Intervention Ethics," Webinar, September 12.
4. 2017, *Invited Participant*, American College of Epidemiology Annual Meeting, Preconference Workshop, "Extreme Personal Exposure Biomarker Levels: Guidance for Study Investigators," New Orleans, Louisiana, September 24.
5. 2016, *Invited Speaker*, American Academy of Pediatrics National Conference & Exhibition, Joint Program: Section on Hospital Medicine and Section on Bioethics, "Resource Allocation: Do We Spend Money to Save One Patient with Ebola or Over a 1,000?" San Francisco, California, October 23.
6. 2016, *Invited Speaker*, 26<sup>th</sup> Annual Specialist Education in Extracorporeal Membrane Oxygenation (SEECHMO) Conference, "Ethical Issues in ECMO: The Bridge to Nowhere," Cincinnati, Ohio, June 5.
7. 2015, *Invited Speaker*, Extracorporeal Life Support Organization (ELSO) 26<sup>th</sup> Annual Conference, "ECMO-Supported Donation after Circulatory Death: An Ethical Analysis," Atlanta, Georgia, September 20.
8. 2014, *Invited Speaker*, Pediatric Evidence-Based Practice 2014 Conference: Evidence Implementation for Changing Models of Pediatric Health Care, "Ethical Issues in Evidence-Based Practice," Cincinnati, Ohio, September 19.
9. 2014, *Invited Speaker*, 6<sup>th</sup> Annual David Kline Symposium on Public Philosophy: Exploring the Synergy Between Pediatric Bioethics and Child Rights, "Does Predictive Genetic Testing for Adult Onset Conditions that Are Not Medically Actionable in Childhood Violate Children's Rights?" Jacksonville, Florida, March 6.
10. 2010, *Invited Speaker*, Quest for Research Excellence: The Intersection of Standards, Culture and Ethics in Childhood Obesity, "Research Integrity and Religious Issues in Childhood Obesity Research," Denver, Colorado, April 21.
11. 2010, *Invited Speaker*, Symposium on the Future of Rights of Conscience in Health Care: Legal and Ethical Perspectives, J. Reuben Clark Law School at Brigham Young University and the Ave Maria School of Law, "Conscientious Objection in Clinical Practice: Disclosure, Consent, Referral, and Emergency Treatment," Provo, Utah, February 26.
12. 2009, *Invited Speaker*, Pediatric Organ Donation Summit, "Research Findings Regarding Variations in Pediatric Hospital Donation after Cardiac Death Policies," Chicago, Illinois, August 18.
13. 2008, *Meet-the-Experts*, American Academy of Pediatrics National Conference & Exhibition, "Physician Refusal to Provide Treatment: What are the ethical issues?" Boston, Massachusetts, October 11.
14. 2008, *Invited Conference Faculty*, Conscience and Clinical Practice: Medical Ethics in the Face of Moral Controversy, The MacLean Center for Clinical Medical Ethics at the University of Chicago, "Defending Positions or Identifying Interests: The Uses of Ethical Argumentation in the Debate over Conscience in Clinical Practice," Chicago, IL, March 18.
15. 2007, *Symposium Speaker*, Alternative Dispute Resolution Strategies in End-of-Life Decisions, The Ohio State University Mortiz College of Law, "The Representation of Children in Disputes at the End-of-Life," Columbus, Ohio, January 18.
16. 2005, *Keynote Speaker*, Decisions and Families, *Journal of Law and Family Studies* and The University of Utah S.J. Quinney College of Law, "Jehovah's Witnesses, Roman Catholicism, and Calvinism: Religion and State Intervention in Parental, Medical Decision-Making," Salt Lake City, Utah, September 23.

Regional/Local

1. 2020, *Keynote Speaker*, 53<sup>rd</sup> Annual Clinical Advances in Pediatrics, “Referral to a Fetal Care Center: How You Can Help Patients’ Mothers Address the Ethical Issues,” Kansas City, Kansas, September 16.
2. 2019, *Speaker*, Patient and Family Support Services, Primary Children’s Hospital, “Ethical Issues in the Care of Trans Adolescents,” Salt Lake City, Utah, December 5.
3. 2019, *Speaker*, Evening Ethics, Program in Medical Ethics and Humanities, University of Utah School of Medicine, “Patients, Parents, and Professionals: Ethical Issues in the Treatment of Trans Adolescents,” Salt Lake City, Utah, December 4.
4. 2019, *Speaker*, Pediatric Hospital Medicine Board Review Course, “Ethics, Legal Issues, and Human Rights including Ethics in Research,” Cincinnati, Ohio, September 8.
5. 2019, *Speaker*, Advances in Fetology, “Evolving Attitudes Toward the Treatment of Children with Trisomies,” Cincinnati, Ohio, September 6.
6. 2019, *Speaker*, Half-Day Ethics Training: Ethics Consultation & Ethics Committees, “Navigating the Rapids of Clinical Ethics Consultation: Intake, Recommendations, and Documentation,” Salt Lake City, Utah, June 1.
7. 2019, *Speaker*, Scientific and Ethical Underpinnings of Gene Transfer/Therapy in Vulnerable Populations: Considerations Supporting Novel Treatments, BioNJ, “What Next? An Ethical analysis of Prioritizing Conditions and Populations for Developing Novel Therapies,” Cranbury, New Jersey, March 7.
8. 2018, *Panelist*, Periviability, 17<sup>th</sup> Annual Regional Perinatal Summit, Cincinnati, Ohio, October 12.
9. 2018, *Speaker*, Regional Advance Practice Registered Nurse (APRN) Conference, “Adults are Not Large Children: Ethical Issues in Caring for Adults in Children’s Hospitals,” Cincinnati, Ohio, April 26.
10. 2018, *Speaker*, Southern Ohio/Northern Kentucky Sigma Theta Tau International Annual Conference, “Between Hope and Hype: Ethical Issues in Precision Medicine,” Sharonville, Ohio, March 2.
11. 2017, *Speaker*, Advances in Fetology 2017, “Ethics of Innovation and Research: Special Considerations in Fetal Therapy Centers,” Cincinnati, Ohio, October 27.
12. 2016, *Speaker*, End-of-Life Pediatric Palliative Care Regional Conference, “Ethical/Legal Issues in Pediatric Palliative Care,” Cincinnati, Ohio, September 15.
13. 2016, *Speaker*, 26<sup>th</sup> Annual Bioethics Network of Ohio (BENO) Conference, “When Does Parental Refusal of Medical Treatment for Religious Reasons Constitute Neglect?” Dublin, Ohio, May 29.
14. 2014, *Speaker*, Cincinnati Comprehensive Sickle Cell Center Symposium: Research Ethics of Hydroxyurea Therapy for Sickle Cell Disease During Pregnancy and Lactation, “Ethical Issues in Research with Pregnant and Lactating Women,” Cincinnati, Ohio, October 30.
15. 2014, *Speaker*, Advances in Fetology 2014, “The ‘Miracle Baby’ and Other Cases for Discussion,” Cincinnati, Ohio, September 26.
16. 2014, *Speaker*, Advances in Fetology 2014, “‘Can you tell me ...?’: Achieving Informed Consent Given the Prevalence of Low Health Literacy,” Cincinnati, Ohio, September 26.
17. 2014, *Panelist*, Center for Clinical & Translational Science & Training, Secrets of the Dead: The Ethics of Sharing their Data, Cincinnati, Ohio, August 28.
18. 2014, *Speaker*, Office for Human Research Protections Research Community Forum: Clinical Research ... and All That Regulatory Jazz, “Research Results and Incidental Findings: Do Investigators Have a Duty to Return Results to Participants,” Cincinnati, Ohio, May 21.
19. 2013, *Opening Presentation*, Empirical Bioethics: Emerging Trends for the 21<sup>st</sup> Century, University of Cincinnati Center for Clinical & Translational Science & Training, “Empirical vs. Normative Ethics: A Comparison of Methods,” Cincinnati, Ohio, February 21.
20. 2012, *Videoconference*, New York State Task Force on Life and the Law, “Pediatric Critical Care Triage,” New York, New York, March 1.
21. 2011, *Presenter*, Fall Faculty Development Workshop, College of Social Work, University of Utah, “Teaching Ethics to Students in the Professions,” Salt Lake City, Utah, November 14.

22. 2011, *Speaker*, 15<sup>th</sup> Annual Conference, Utah Chapter of the National Association of Pediatric Nurse Practitioners, “Ethical Issues in Pediatric Practice,” Salt Lake City, Utah, September 22.
23. 2011, *Speaker*, Code Silver! Active Shooter in the Hospital, Utah Hospitals & Health Systems Association, Salt Lake City, Utah, March 21.
24. 2009, *Speaker*, Medical Staff Leadership Conference, Intermountain Healthcare, “The Ethics of Leadership,” Park City, Utah, October 30.
25. 2008, *Speaker*, The Art and Medicine of Caring: Supporting Hope for Children and Families, Primary Children’s Medical Center, “Medically Provided Hydration and Nutrition: Ethical Considerations,” Salt Lake City, Utah, February 25.
26. 2005, *Speaker*, Utah NAPNAP (National Association of Pediatric Nurse Practitioners) Chapter Pharmacology and Pediatric Conference, “Immunization Update,” Salt Lake City, Utah, August 18.
27. 2005, *Keynote Speaker*, 17th Annual Conference, Utah Society for Social Work Leadership in Health Care, “Brain Death: Accommodation and Consultation,” Salt Lake City, March 18.
28. 2004, *Continuing Education Presentation*, Utah NAPNAP (National Association of Pediatric Nurse Practitioners), “Febrile Seizures,” Salt Lake City, Utah, April 22.
29. 2004, *Speaker*, Advocacy Workshop for Primary Care Providers, “Ethics of Advocacy,” Park City, Utah, April 3.
30. 2002, *Speaker*, 16<sup>th</sup> Annual Biologic Basis of Pediatric Practice Symposium, “Stem Cells: Religious Perspectives,” Deer Valley, Utah, September 14.

## Meeting Presentations

### International

1. 2018, *Speaker*, International Conference on Clinical Ethics and Consultation, “A Systematic Review of Typologies Used to Characterize Clinical Ethics Consultations,” Oxford, United Kingdom, June 21.

### National

1. 2021, *Panelist*, Pediatric Endocrine Society Annual Meeting, Difference of Sex Development Special Interest Group, Virtual Conference, April 29.
2. 2020, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Is This Child Dead? Controversies Regarding the Neurological Criteria for Death,” Virtual Conference, October 17.
3. 2020, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Contemporary Ethical Controversy in Fetal Therapy: Innovation, Research, Access, and Justice,” Virtual Conference, October 15.
4. 2020, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “K-12 Schools and Mandatory Public Health Programs During the COVID-19 Pandemic,” Virtual Conference, October 15.
5. 2019, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Ethical Issues in Translating Gene Transfer Studies Involving Children with Neurodegenerative Disorders,” Pittsburgh, Pennsylvania, October 26.
6. 2019, *Moderator*, Pediatric Academic Societies Annual Meeting, Clinical Bioethics, Baltimore, Maryland, April 28.
7. 2018, *Presenter*, American Society for Bioethics and Humanities Annual Meeting, “Looking to the Past, Understanding the Present, and Imaging the Future of Bioethics and Medical Humanities’ Engagement with Transgender Health,” Anaheim, California, October 19.
8. 2018, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Should Vaccination Be a Prerequisite for Sold Organ Transplantation?” Anaheim, California, October 18.
9. 2018, Lindsey Douglas, Armand H. Matheny Antommaria, Derek Williams. *Workshop Presenter*, Pediatric Hospital Medicine Annual Meeting, “IRB Approved! Tips and Tricks to Smooth Sailing through the Institutional Review Board (IRB).” Atlanta, Georgia, July 20.

10. 2018, Alan Schroeder, Armand H. Matheny Antommara, Hannah Bassett, Kevin Chi, Shawn Ralston, Rebecca Blankenburg. *Workshop Speaker*, Pediatric Hospital Medicine Annual Meeting, “When You Don’t Agree with the Plan: Balancing Diplomacy, Value, and Moral Distress,” Atlanta, Georgia, July 20.
11. 2018, Alan Schroeder, Hannah Bassett, Rebecca Blankenburg, Kevin Chi, Shawn Ralston, Armand H. Matheny Antommara. *Workshop Speaker*, Pediatric Academic Societies Annual Meeting, “When You Don’t Agree with the Plan: Balancing Diplomacy, Value, and Moral Distress,” Toronto, Ontario, Canada, May 7.
12. 2017, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Tensions in Informed Consent for Gender Affirming Hormone Therapy and Fertility Preservation in Transgender Adolescents,” Kansas City, Missouri, October 19.
13. Lindsey Douglas, Armand H. Matheny Antommara, and Derek Williams. 2017, *Workshop Leader*, PHM[Pediatric Hospital Medicine]2017, “IRB Approved! Tips and Tricks to Smooth Sailing through the Institutional Review Board (IRB) Process,” Nashville, Tennessee, July 21.
14. 2016, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Ethical Challenges in the Care of International Patients: Organization, Justice, and Cultural Considerations,” Washington, DC, October 9.
15. 2015, *Coauthor*, The American Society of Human Genetics Annual Meeting, “Adolescents’ Opinions on Disclosure of Non-Actionable Secondary Findings in Whole Exome Sequencing,” Baltimore, Maryland, October 9.
16. 2012, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “A Public Health Ethics Analysis of the Mandatory Immunization of Healthcare Personnel: Minimizing Burdens and Increasing Fairness,” Washington, DC, October 21.
17. Armand H. Matheny Antommara, Valerie Gutmann Koch, Susie A. Han, Carrie S. Zoubul. 2012, *Moderator*, American Society for Bioethics and Humanities Annual Meeting, “Representing the Underrepresented in Allocating Scarce Resources in a Public Health Emergency: Ethical and Legal Considerations,” Washington, DC, October 21.
18. 2012, *Platform Presentation*, Pediatric Academic Societies Annual Meeting, “Qualitative Analysis of International Variation in Donation after Circulatory Death Policies and Rates,” Boston, Massachusetts, April 30. Publication 3150.4.
19. 2011, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “The Intersection of Policy, Medicine, and Ethics during a Public Health Disaster: Special Considerations for Children and Families,” Minneapolis, Minnesota, October 13.
20. Armand H. Matheny Antommara and Joel Frader. 2010, *Workshop Leader*, Pediatric Academic Societies Annual Meeting, “Conscientious Objection in Health Care: Respecting Conscience and Providing Access,” Vancouver, British Columbia, Canada. May 1. Session 1710.
21. 2009, *Workshop Leader*, American Society for Bioethics and Humanities Annual Meeting, “Advanced Clinical Ethics Consultation Skills Workshop: Process and Interpersonal Skills,” Washington, DC, October 15.
22. 2009, *Platform Presentation*, Pediatric Academic Societies Annual Meeting, “Qualitative Analysis of Donation after Cardiac Death Policies at Children’s Hospitals,” Baltimore, Maryland, May 2. Publication 2120.6.
23. 2008, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Qualitative Analysis of Donation After Cardiac Death (DCD) Policies at Children’s Hospitals,” Cleveland, Ohio, October 26.
24. 2007, *Participant*, Hamline University School of Law Biennial Symposium on Advanced Issues in Dispute Resolution, “An Intentional Conversation About Conflict Resolution in Health Care,” Saint Paul, Minnesota, November 8-10.
25. 2007, *Speaker*, American Society of Bioethics and Humanities Annual Meeting, “Bioethics Consultation and Alternative Dispute Resolution: Opportunities for Collaboration,” Washington, DC, October 21.

26. 2007, *Speaker*, American Society of Bioethics and Humanities Annual Meeting, “DNAR Orders in Schools: Collaborations Beyond the Hospital,” Washington, DC, October 18.
27. Armand H. Matheny Antommaria and Jeannie DePaulis. 2007, *Speaker*, National Association of Children’s Hospitals and Related Institutions Annual Meeting, “Using Mediation to Address Conflict and Form Stronger Therapeutic Alliances,” San Antonio, Texas, October 9.
28. 2006, *Speaker*, American Society of Bioethics and Humanities Annual Meeting, “Bioethics Mediation: A Critique,” Denver, Colorado, October 28.
29. 2005, *Panelist*, American Society of Bioethics and Humanities Annual Meeting, “How I See This Case: ‘He Is Not His Brain,’” Washington, DC, October 20.
30. 2005, *Paper Presentation*, Pediatric Ethics: Setting an Agenda for the Future, The Cleveland Clinic, “‘He Is Not His Brain:’ Accommodating Objections to ‘Brain Death,’” Cleveland, Ohio, September 9.
31. 2004, *Speaker*, American Society for Bioethics and Humanities Spring Meeting, “Verification and Balance: Reporting Within the Constraints of Patient Confidentiality,” San Antonio, Texas, March 13.
32. 2002, *Panelist*, American Society for Bioethics and Humanities Annual Meeting, “‘Who Should Survive?:’ Mental Retardation and the History of Bioethics,” Baltimore, Maryland, October 24.

#### **Invited/Visiting Professor Presentations**

1. 2013, Visiting Professor, “How to Listen, Speak and Think Ethically: A Multidisciplinary Approach,” Norton Suburban Hospital and Kosair Children’s Hospital, Louisville, Kentucky, May 22.
2. 2010, Visiting Professor, Program in Bioethics and Humanities and Department of Pediatrics, “What to Do When Parents Want Everything Done: ‘Futility’ and Ethics Facilitation,” University of Iowa Carver College of Medicine, Iowa City, Iowa, September 10.

#### **Grand Round Presentations**

1. 2019, David Green Lectureship, “Establishing Goals of Care and Ethically Limiting Treatment,” Primary Children’s Hospital, Salt Lake City, Utah, December 5.
2. 2018, “The Ethics of Medical Intervention for Transgender Youth,” El Rio Health, Tucson, Arizona, September 29.
3. 2018, Pediatrics, “Patient Selection, Justice, and Cultural Difference: Ethical Issues in the Care of International Patients,” Cleveland Clinic, Cleveland, Ohio, April 10.
4. 2018, Bioethics, “Reversibility, Fertility, and Conflict: Ethical Issues in the Care of Transgender and Gender Nonconforming Children and Adolescents,” Cleveland Clinic, Cleveland, Ohio, April 9.
5. 2017, Heart Institute, “‘Have you ever thought about what you would want—if god forbid—you became sicker?’: Talking with adult patients about advance directives,” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, October 16.
6. 2017, Pediatrics, “Respectful, Effective Treatment of Jehovah’s Witnesses,” with Judith R. Ragsdale, PhD, MDiv and David Morales, MD, Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, March 14.
7. 2017, Pediatrics, “Ethical Dilemmas about Discharging Patients When There Are Disagreements Concerning Safety,” Seattle Children’s Hospital, Seattle, Washington, January 19.
8. 2015, Pediatrics, “‘Nonbeneficial’ Treatment: What must providers offer and what can they withhold?,” Greenville Health System, Greenville, South Carolina, May 10.
9. 2014, Advance Practice Providers, “Common Ethical Issues,” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, August 13.
10. 2014, Respiratory Therapy, “Do-Not-Resuscitate (DNR) Orders,” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, July 15.
11. 2013, Heart Institute, “No Not Months. Twenty-Two Years-Old: Transiting Patients to an Adult Model of Care.” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, October 21.

12. 2013, Division of Neonatology, “This Premature Infant Has a *BRCA1* Mutation!?: Ethical Issues in Clinical Whole Exome Sequencing for Neonatologists.” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, October 11.
13. 2013, Department of Pediatrics, “Adults are Not Large Children: Ethical Issues in Caring for Adults in Children’s Hospitals,” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, February 26.
14. 2012, “Mandate or Moratorium?: Persisting Ethical Controversies in Donation after Circulatory Death,” Cedars-Sinai Medical Center, Los Angeles, California, May 16.
15. 2011, Division of Pediatric Neurology Friday Lecture Series, “Inducing or Treating ‘Seizures’ with Placebos: Is It Ever Ethical?,” University of Utah, Salt Lake City, Utah, October 7.
16. 2011, Department of Surgery, “DNR Orders in the OR and other Ethical Issues in Pediatric Surgery: Case Discussions,” Primary Children’s Medical Center, Salt Lake City, Utah, October 3.
17. 2009, Department of Pediatrics, “What to Do When Parents Want Everything Done: ‘Futility’ and Bioethical Mediation,” Primary Children’s Medical Center, Salt Lake City, Utah, September 17.
18. 2008, Division of Pulmonology and Critical Care, “Futility: May Clinicians Ever Unilaterally Withhold or Withdraw Medical Treatment?” Utah Valley Regional Medical Center, Provo, Utah, April 17.
19. 2007, Division of Otolaryngology-Head and Neck Surgery, “Advance Directives, Durable Powers of Attorney for Healthcare, and Do Not Attempt Resuscitation Orders: Oh My!,” University of Utah School of Medicine, Salt Lake City, Utah, June 20.

#### **Outreach Presentations**

1. 2019, *Panelist*, Cincinnati Edition, WVXU, “The Ethics of Human Gene Editing,” Cincinnati, Ohio, June 13.
2. 2019, *Speaker*, Adult Forum, Indian Hill Church, “Medical Ethics,” Indian Hill, Ohio, March 24.
3. 2016, *Speaker*, Conversations in Bioethics: The Intersection of Biology, Technology, and Faith, Mt. Washington Presbyterian Church, “Genetic Testing,” Cincinnati, Ohio, October 12.
4. 2008, *Speaker*, Science in Society, Co-sponsored by KCPW and the City Library, “Death—Choices,” Salt Lake City, Utah, November 20.
5. 2003, *Panelist*, Utah Symposium in Science and Literature, “The Goodness Switch: What Happens to Ethics if Behavior is All in Our Brains?” Salt Lake City, Utah, October 10.
6. 2002, *Respondent*, H. Tristram Englehardt, Jr. “The Culture Wars in Bioethics,” Salt Lake Community College, Salt Lake City, Utah, March 29.

**EXHIBIT B**  
**Bibliography**

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