UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER; BRIANNA BOE, individually and on behalf of her minor son, MICHAEL BOE; JAMES ZOE, individually and on behalf of his minor son, ZACHARY ZOE; MEGAN POE, individually and on behalf of her minor daughter, ALLISON POE; KATHY NOE, individually and on behalf of her minor son, CHRISTOPHER NOE; JANE MOE, Ph.D.; and RACHEL KOE, M.D.,

Plaintiffs,

v.

KAY IVEY, in her official capacity as Governor of the State of Alabama; STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama; DARYL D. BAILEY, in his official capacity as District Attorney for Montgomery County; C. WILSON BAYLOCK, in his official capacity as District Attorney for Cullman County; JESSICA VENTIERE, in her official capacity as District Attorney for Lee County; TOM ANDERSON, in his official capacity as District Attorney for the 12th Judicial Circuit; and DANNY CARR, in his official capacity as District Attorney for Jefferson County,

Defendants.

Civil Action No.
2:22-cv-00184-184-LCB

Hon. Liles C. Burke

MEMORANDUM IN SUPPORT OF
PLAINTIFFS' MOTION FOR TEMPORARY
RESTRAINING ORDER & PRELIMINARY INJUNCTION

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I. INTRODUCTION

Plaintiffs are a church pastor, parents, and healthcare providers who seek to ensure that the Plaintiff children in this case receive necessary medical care. The Reverend Paul Eknes-Tucker is the Senior Pastor at a Birmingham church who has provided pastoral counseling to congregants and community members who are parents of transgender children. Brianna Boe, James Zoe, Megan Poe, and Kathy Noe (together, "Parent Plaintiffs") are parents of children who are currently receiving medical care for gender dysphoria; they are suing individually and on behalf of their children. Michael Boe, Zachary Zoe, Allison Poe, and Christopher Noe (together, "Transgender Plaintiffs") are transgender minors whose medical care will be halted or precluded by the Act. Dr. Jane Moe and Dr. Rachel Koe (together, "Healthcare Provider Plaintiffs") are healthcare providers who will be subjected to felony arrest and potential imprisonment for providing recommended medical care to their patients—care recognized as medically appropriate and necessary by every major expert medical association—if the Alabama Vulnerable Child Compassion and Protection Act (the "Act") goes into effect on May 8, 2022.

II. STATEMENT OF FACTS

A. The Act Prevents the Parent Plaintiffs from Receiving the Support They Need to Make Important Medical Decisions for their Children's Health and Well-Being.

1. Reverend Paul Eknes-Tucker

Rev. Paul Eknes-Tucker is the Senior Pastor at Pilgrim Church in Birmingham, Alabama where he has served for seven years. (*See* Declaration of Rev. Paul Eknes-Tucker ("Rev. Eknes-Tucker Decl.") ¶ 1.) A core tenet of his faith is love, respect, and support for all persons. (*Id.* ¶ 4.) In his pastoral role, he has provided counseling to congregants and community members who are the parents of transgender children. (*Id.* ¶ 5.) In those discussions, parents are often uncertain about what guidance their faith can provide as they figure out how to support their child. (*Id.*) Parents often share with Rev. Eknes-Tucker their worries and fears as well as hopes and aspirations for their transgender child's future. (*Id.* ¶ 6.) His religious faith compels him to support parents in accepting their transgender children. (*Id.*) This includes counseling parents to get help from medical and mental health professionals, when needed, to assist and care for their children and to embrace who they are. (*Id*.)

2. Brianna Boe and Her Son Michael Boe

Michael Boe is a twelve-year-old transgender boy who resides with his mother, Brianna, in Montgomery County, Alabama. (*See* Declaration of Brianna Boe ("Boe Decl.") ¶¶ 1-2.) In his early years, Michael was a happy, outgoing child.

(*Id.* ¶ 3.) At nine years old, however, Michael became depressed and anxious. (*Id.*) Michael also started struggling academically and socially. (*Id.*) Michael eventually confided in his mother that he felt as though he was not like other girls and was worried about being judged by his classmates. (*Id.* ¶ 4.) He also reported that he was being bullied in school. (*Id.*) Brianna placed Michael in a new school for the following school year and brought him to a therapist to help him with his depression. (*Id.* ¶ 5.)

Michael began to talk with his mother about his male gender identity and the distress and discomfort he was experiencing as he entered puberty and his body began to develop in ways that were inconsistent with his sense of self. (*Id.* ¶¶ 5-6.) In June 2021, Michael told his mother that he is transgender. (*Id.* ¶ 7.) With support from his family and a mental health provider experienced in working with transgender youth, Michael began to socially transition, including adopting a male name and pronouns and generally living as a boy in all aspects of his life. (*Id.* ¶¶ 7-9.)

Since Michael began to socially transition, his mood has improved greatly. (*Id.* ¶ 9.) His therapist recently recommended that Michael be evaluated for additional medical treatment to address the distress he continues to experience due to the mismatch between his body and his gender identity. (*Id.* ¶¶ 9-12.)

In February 2022, Brianna made an initial appointment for Michael at the Children's Hospital of Alabama. (*Id.* ¶ 14.) If this law goes into effect, that

appointment will be cancelled, and Michael cannot be assessed for critical medical care. (*Id.* ¶¶ 14-15.) In addition, he will continue to experience the effects of female puberty which will cause him to develop additional physical traits inconsistent with his identity as a boy and will severely exacerbate his distress. (*Id.* ¶¶ 9-12, 15.)

3. Megan Poe and Her Daughter Allison Poe

Allison Poe is a fifteen-year-old transgender girl who resides with her mother, Megan Poe, in Cullman County, Alabama. (*See* Declaration of Megan Poe ("Poe Decl.") ¶¶ 1-3.) As a young child, Allison showed interest in girls' toys and clothing. (*Id.* ¶ 4.) Thinking this was a phase, her parents initially refused to buy Allison any girl toys. (*Id.*) Without asking, Allison's grandmother bought Allison a Barbie doll. (*Id.*) Allison was so happy and carried it everywhere. (*Id.*)

When the family returned to the United States from her father's deployment abroad, Allison would become very upset when her mother refused to buy her girls' clothes. (*Id.* ¶ 5.) As a compromise and remembering Allison's response to the grandmother buying her a doll, Megan bought Allison a few girls' toys, again providing Allison some short-term relief from the despair she was experiencing. (*Id.*) When Allison was around nine years old, her personality began to change significantly. (*Id.* ¶ 9.) She became withdrawn and quiet, showed signs of depression, and regularly commented that she wanted to die. (*Id.*) Allison's actions became so worrisome to Megan that she consulted with a pediatrician. (*Id.* ¶ 10.)

The pediatrician suggested that Allison may be transgender and referred them to the gender clinic at the University of Alabama at Birmingham ("UAB") Hospital. (*Id.*)

After evaluating Allison, a team of clinicians educated Megan about what Allison was experiencing and gave her professional advice about how to support Allison. (*Id.* ¶¶ 11-12.) That visit was a turning point for Megan. (*Id.* ¶ 13.) Having a better understanding of what Allison was experiencing and receiving guidance about how to support her child's ability to thrive, Megan helped Allison redecorate her room and began buying girls' clothes for her. (*Id.* ¶ 14.) The first time Allison emerged from her room in girls' clothes she was beaming with joy. (*Id.*)

During fifth grade, in anticipation of her starting puberty, Allison was evaluated for puberty-blocking medication, which she started taking at the end of sixth grade. (*Id.* ¶¶ 18-19.) About seven months ago, just as Allison was beginning high school, she was evaluated for and eventually started on estrogen. (*Id.* ¶ 21.) Her mental health has improved dramatically; she is confident, social, and doing well in school. (*Id.* ¶ 22.) If the Act is allowed to go into effect, Allison's medical care will be disrupted, which will cause her body to start producing male hormones resulting in changes to her body inconsistent with her female identity. (*Id.* ¶ 23.) Should that happen, Allison will again experience severe distress and anxiety. (*Id.*)

4. James Zoe and His Son Zachary Zoe

James Zoe lives with his wife and son Zachary in Jefferson County, Alabama. (*See* Declaration of James Zoe ("Zoe Decl.") ¶¶ 1-2.) He is the parent of Zachary Zoe, a thirteen-year-old transgender boy who is currently in the seventh grade. (*Id.* ¶ 2.) Zachary lives part-time with his father and stepmother in Jefferson County, and part-time with his mother and stepfather in St. Clair County. (*Id.* ¶ 5.) Zachary is a bright boy with a close group of friends who is interested in video games and art. (*Id.*)

Zachary was assigned female at birth. (*Id.* ¶ 6.) As a young child, Zachary was shy and reserved. (*Id.*) Around the age of eight, Zachary began to express his dislike of wearing dresses and bright clothing. (*Id.*) Over time, Zachary started dressing in more masculine attire and became upset if people identified him as a girl. (*Id.*)

As Zachary entered puberty, the physical changes he started to experience, including breast development and menstruation, caused him to become distressed and withdrawn. (*Id.* ¶ 7.) When Zachary was eleven years old, he began referring to himself using "he" and "him" pronouns. (*Id.* ¶ 8.) As his friends began to refer to him in this way, he experienced relief from the distress he had been experiencing as well as a greater sense of self-awareness and self-acceptance. (*Id.*) Both sets of parents supported him in socially transitioning to live as a boy. (*Id.*) Since he came

out as transgender and received support from friends and family, Zachary has blossomed into a happier and more outgoing child. (*Id*. ¶ 9.)

In October 2021, after completing appropriate mental health evaluations, and with the support of his pediatrician and both sets of parents, Zachary began puberty-blockers. (*Id*. ¶ 10.) He recently had an appointment to be assessed for hormone therapy at Children's Hospital of Alabama at Birmingham. (*Id*.)

If the Act is enforced, Zachary's parents will no longer be able to rely on—or follow—the advice of qualified and trusted healthcare providers to make decisions that keep Zachary healthy and safe. (*Id*. ¶ 11.) Zachary's life will also be disrupted, and his physical and mental health will suffer. (*Id*. ¶ 13.) If he cannot remain on puberty blocking medication, Zachary's body will begin to develop in ways that are inconsistent with his identity as a boy, which will cause him severe distress. (*Id.*) It will also mean that he may have to take more serious steps in the future as an adult to treat his gender dysphoria, including, for example, having to undergo otherwise avoidable surgery. (*Id.*)

5. Kathy Noe and Her Son Christopher Noe

Christopher Noe is a seventeen-year-old transgender boy who resides with his mother, Kathy Noe, in Lee County, Alabama. (*See* Declaration of Kathy Noe ("Noe Decl.") ¶¶ 1-2.) Christopher and Kathy moved to Alabama when Christopher was

three years old. (*Id*. ¶¶ 3-4.) Kathy is former active-duty military, while Christopher's father is still active-duty military and is deployed abroad. (*Id.* ¶ 3.)

Since Christopher was a toddler, he resisted anyone's attempts to dress him as a girl. (*Id*. ¶¶ 5-6.) He even refused to attend his sixth-grade graduation because doing so meant he would have to wear a dress. (*Id*. ¶ 6.) As Christopher began to enter puberty, his distress at the changes his body was undergoing and at being made to present as female intensified. (*Id*. ¶ 12.) When Christopher was fourteen, he told his mother he is transgender. (*Id*. ¶ 8.) Kathy found Christopher a therapist experienced in working with transgender young people. (*Id*. ¶ 9.) The therapist helped both Christopher and Kathy navigate the beginning stages of Christopher's transition. (*Id*.)

About a year later, Christopher came out to his father as transgender. (*Id*. ¶ 10.) Christopher's father struggled initially, but because of his love for Christopher, his father began to accept Christopher for who he is. (*Id.*) With his father's support, Kathy took Christopher to a physician to begin the evaluation for hormone therapy. (*Id*. ¶¶ 10, 14.) Because Kathy and Christopher live close to the Alabama-Georgia state line, Christopher's doctors are in Columbus, Georgia. (*Id.* ¶ 16.) Christopher's prescriptions, however, are filled in Alabama, and Kathy gives Christopher his hormone injections at home. (*Id.* ¶¶ 15-16.)

Christopher began hormone therapy in March 2022. (*Id.* ¶ 15.) Since then, Christopher has been noticeably happier. (*Id.* ¶ 17.) He is more outgoing and confident at work and around other people. (*Id.*) If the Act is allowed to go into effect, Christopher's medical care will be disrupted, which will have devastating and irreversible physical and psychological consequences. (*Id.* ¶ 18.)

6. Dr. Jane Moe

Dr. Jane Moe is a licensed clinical psychologist who has been practicing in Alabama for twenty years and works in a hospital setting within the UAB system providing direct mental health care to children and adolescents. (*See* Declaration of Dr. Jane Moe ("Moe Decl.") ¶¶ 1-4.) For the past two years, Dr. Moe has treated approximately forty transgender young people, ranging in age from five to nineteen. (*Id.* ¶ 4.)

She follows the standard of care developed by the World Professional Association for Transgender Health ("WPATH") and a comprehensive informed-consent protocol. (*Id.* ¶ 5.) Her assessment of transgender youth involves parents as well as the patient. (*Id.* ¶¶ 5-6.) The process requires a minimum of three to four visits, which typically take place over the course of two to three months. (*Id.* ¶ 6.) The assessment is comprehensive and involves many different methods of gathering information on the patient, including discussions with the parents, to determine whether they meet the diagnostic criteria for gender dysphoria. (*Id.* ¶¶ 7-8.)

Dr. Moe also reviews with the patient and the patient's parents the risks, benefits, and ranges of medical treatment available and appropriate for treating any patient's condition. (*Id*. ¶ 9.) Dr. Moe then writes a letter to the patient's doctor detailing the results of her assessment and recommendations for continued care. (*Id*. ¶¶ 9, 11.)

For Dr. Moe, the Act means that she must either abandon her professional and ethical obligations when treating transgender patients or risk criminal penalty for providing mental health care consistent with the prevailing standards of care. (*Id*. ¶ 14.) She is deeply concerned about the effects this law will have on her patients' mental health, many of whom already experience bullying and harassment in their schools and communities. (*Id*. ¶ 15.) She is concerned that if healthcare providers are required to comply with the Act, transgender youth will be denied essential care. (*Id*. ¶ 13.) Their mental health will deteriorate, impairing their ability to function in their day-to-day lives. (*Id*. ¶ 16.) That decline in mental health will cause a cascade of negative health outcomes, including exacerbating co-occurring mental health issues, increased reliance on maladaptive coping mechanisms (*e.g.*, cutting, substance abuse), and suicidality. (*Id*.)

7. Dr. Rachel Koe

Dr. Rachel Koe is a board-certified pediatrician in southeast Alabama. (*See* Declaration of Dr. Rachel Koe ("Koe Decl.") ¶¶ 1-3.) Over the past decade, Dr. Koe

has treated a handful of transgender patients, including one current patient for whom she provides primary care. (*Id.* ¶¶ 4, 9-10.) Depending on need, Dr. Koe has referred transgender patients and their parents to local mental health providers as well as the gender clinic at UAB Hospital. (*Id*. ¶¶ 5, 9.) Even after referral, Dr. Koe remains involved with her transgender patients' care, as she does for other patients referred for specialty treatments. (*Id.* ¶¶ 6, 9.) For example, Dr. Koe's office draws blood for their transgender patient's regular blood work in advance of appointments with the gender clinic. (*Id.*) Additionally, she and her staff provide support to patients who need assistance in self-administering injectable hormone medications like testosterone. (*Id.*)

If the Act goes into effect, Dr. Koe will be forced to choose between complying with the Act and providing for the medical needs of her current and any future transgender patients. (*Id*. ¶¶ 11-13.) She knows that if she does not provide the medical treatments they need, her transgender patients' mental and physical health will deteriorate. (*Id.* ¶ 11.) Because of the Act, Dr. Koe will also be required to curtail her speech as she will no longer be allowed to provide accurate and comprehensive information to parents of transgender children and will be prohibited from making appropriate referrals. (*Id*. ¶ 12.) Changing her practice in these ways would also put Dr. Koe in jeopardy of violating her legal obligation as a Medicaid

provider not to discriminate in the provision of medical care to her transgender patients. (*Id*. ¶ 13.)

B. Transition Is the Established Course of Care for Gender Dysphoria.

Gender dysphoria is a serious medical condition that has been recognized for decades (*See* Declaration of Dr. Linda Hawkins ("Hawkins Decl.") ¶ 25; Declaration of Dr. Stephen Rosenthal ("Rosenthal Decl.") ¶¶ 23-24.) The diagnosis describes the clinical distress a transgender person feels from being made to live without any way to resolve the conflict between their assigned sex and their gender identity. (Hawkins Decl. ¶ 24; Rosenthal Decl. ¶¶ 26-27.) Gender dysphoria is a rare condition that can be experienced by both adults and youth. (Rosenthal Decl. ¶ 24.) If untreated, gender dysphoria leads to serious negative health outcomes including anxiety, severe distress, thoughts or attempts at self-harm, and in many cases, suicide. (Hawkins Decl. ¶ 39; Rosenthal Decl. ¶¶ 26, 45, 55.)

Gender dysphoria, however, is highly treatable. (Rosenthal Decl. ¶ 26.) When individuals with gender dysphoria are diagnosed and medically treated so they live consistent with their gender identity, they can survive and thrive. (Hawkins Decl. ¶ 26; Rosenthal Decl. ¶ 36.) The overall course of treatment that allows a transgender person to live consistent with their gender identity is called transition. (Rosenthal Decl. ¶ 32.) While few minors experience gender dysphoria, for those who do, being

able to transition and to receive appropriate medical care is lifesaving. (Hawkins Decl. ¶ 41; Rosenthal Decl. ¶ 45.)

For more than four decades, medical organizations have studied and created an evidence-based standard for the medical treatment of transgender patients. (*See* Declaration of Dr. Morissa Ladinsky ("Ladinsky Decl.") ¶ 7; Rosenthal Decl. ¶¶ 2-24, 27-31.) This standard confirms that transition, including puberty blockers and hormone therapy where appropriate, is the only safe and effective treatment for gender dysphoria. (Hawkins Decl. ¶ 38; Rosenthal Decl. ¶ 23.)

The specific components of a patient's transition and treatment plan are based on that individual's medical and mental health needs after comprehensive evaluation by a multidisciplinary team. (Ladinsky Decl. ¶¶ 10-12; Rosenthal Decl. ¶¶ 5, 33, 46.) Qualified professionals manage these treatments, often in a multidisciplinary setting with endocrinologists, pediatricians, and clinical psychologists. (Hawkins Decl. ¶ 29; Ladinsky Decl. ¶ 10; Rosenthal Decl. ¶¶ 5, 47-48.) The American Academy of Pediatrics has adopted this treatment protocol as safe and effective for the health and wellbeing of children and adolescents suffering from gender dysphoria. (Hawkins Decl. ¶ 25; Ladinsky Decl. ¶ 7; Rosenthal Decl. ¶ 30.)

Before a minor begins any treatment for gender dysphoria, health care providers undertake a rigorous informed consent process. (Hawkins Decl. ¶ 36; Ladinsky Decl. ¶¶ 9-10; Rosenthal Decl. ¶¶ 48-51.) Once informed consent is

obtained, there is also a great deal of parent education, counseling of parents, and communication among physicians in the treatment of transgender adolescents. (Hawkins Decl. ¶¶ 36-37; Ladinsky Decl. ¶¶ 10-12; Rosenthal Decl. ¶ 47.)

The standard of care for the treatment of gender dysphoria in minors consists of social transition and related medical interventions that allow transgender youth to live comfortably consistent with their gender identity. (Hawkins Decl. ¶¶ 27-29; Rosenthal Decl. ¶ 32.) A young person's social transition can include adopting a new name and pronouns, changing clothes and physical appearance, and correcting identity documents. (Hawkins Decl. ¶¶ 27-29; Rosenthal Decl. ¶ 32.) Medical interventions, which may be pursued concurrently with a social transition, can involve the use of puberty-blocking medication, and for older adolescents, hormone therapy. (Hawkins Decl. ¶ 29; Rosenthal Decl. ¶¶ 35-41.) Although transgender adults may pursue surgical treatment, surgery is rarely indicated for transgender minors. (Rosenthal Decl. ¶ 46.)

After the onset of puberty, minors diagnosed with gender dysphoria may be prescribed puberty-blocking medications to prevent them from continuing to undergo puberty in their birth sex and developing permanent physical characteristics that conflict with their gender identity. (*Id*. ¶¶ 35-38.) Puberty-blocking medications work by pausing endogenous puberty at whatever stage it is when the treatment begins, limiting the influence of a person's endogenous hormones on their body.

(*Id*. ¶ 36.) For example, a transgender girl on puberty-blocking medications would not experience the physical changes caused by testosterone, including facial and body hair, male muscular development, an Adam's apple, or masculinized facial structures. (*Id*.) Similarly, a transgender boy would not experience breast development, menstruation, or widening of the hips. (*Id*.)

Treatment with puberty-blocking medications is reversible, meaning that if a minor stops taking the medication, puberty in the minor's birth sex resumes. (*Id.* ¶¶ 38-39.) In addition to alleviating gender dysphoria and supporting a child's social transition, puberty-blocking medications may eliminate the need for future surgical treatments to treat ongoing gender dysphoria as an adult, such as male chest reconstruction surgery, electrolysis of facial and body hair, and feminizing facial surgeries. (*Id.* ¶¶ 36-37, 44.) Banning puberty-blocking medications for these youth may require them to undergo future surgeries as adults that they could otherwise avoid. (*Id*.).

Later in adolescence, a transgender young person may be prescribed hormone therapy when doing so is medically indicated. (*Id*. ¶ 39.) Before such therapy begins, a mental health professional must: (1) confirm the persistence of gender dysphoria; (2) assess any coexisting psychological, medical, or social problems that could interfere with treatment have been addressed and the minor's situation and functioning are stable enough to start treatment; and (3) verify that the minor has

sufficient mental capacity to understand the consequences of the treatment. (*Id*. ¶¶ 48-51; Hawkins Decl. ¶ 36; Ladinsky Decl. ¶¶ 9-11.) A pediatric endocrinologist or other medical doctor must also consent to and monitor the treatment plan. (Ladinsky Decl. ¶ 13.) With this treatment, a transgender minor would have the same typical levels of testosterone/estrogen as a non-transgender peer. (Rosenthal Decl. ¶ 39.)

The World Professional Association for Transgender Health developed the standard of care, which represents an expert consensus based on the best available science, on transgender healthcare. (Ladinsky Decl. ¶ 7; Rosenthal Decl. ¶¶ 28-29.) The American Medical Association, American Academy of Pediatrics, American Psychiatric Association, American Psychological Association, Pediatric Endocrine Society, and the Endocrine Society all follow the World Professional Association for Transgender Health Standards of Care. (Ladinsky Decl. ¶ 7; Dr. Rosenthal Decl. ¶ 30.)

The diagnosis and treatment of gender dysphoria is an established part of the curriculum in medical schools across the United States. (Ladinsky Decl. ¶ 8.) Alabama, for example, requires all physicians to be knowledgeable about transgender medicine to pass medical board exams. (*Id*.)

C. The Alabama Vulnerable Child Compassion and Protection Act

On April 8, 2022, Defendant Governor Kay Ivey signed the Alabama Vulnerable Child Compassion and Protection Act (the "Act") into law. The Act prohibits any person, including a parent or a doctor, from obtaining or providing medical treatments consistent with the current medical standard of care, for a transgender minor. Unless enjoined, the Act will become effective on May 8, 2022.

The Act states in relevant part:

> Section 4. (a) Except as provided in subsection (b), no person shall engage in or cause any of the following practices to be performed upon a minor if the practice is performed for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that perception is inconsistent with the minor's sex as defined in this act:
>
> (1) Prescribing or administering puberty blocking medication to stop or delay normal puberty.
>
> (2) Prescribing or administering supraphysiologic doses of testosterone or other androgens to females.
>
> (3) Prescribing or administering supraphysiologic doses of estrogen to males.
>
> (4) Performing surgeries that sterilize, including castration, vasectomy, hysterectomy, oophorectomy, orchiectomy, and penectomy.
>
> (5) Performing surgeries that artificially construct tissue with the appearance of genitalia that differs from the individual's biological sex, including metoidioplasty, phalloplasty, and vaginoplasty.
>
> (6) Removing any healthy or non-diseased body part or tissue, except for a male circumcision.

Ala. Vulnerable Child Compassion and Protection Act, S.B. 184, No. 2022-289, § 4(a) (Ala. 2022). A violation of this provision is a Class C felony punishable by up to 10 years imprisonment and fines up to $15,000. *Id.* § 4(c); ALA. CODE §§ 13A-5-6, 13A-5-11.

III. ARGUMENT

To obtain a preliminary injunction, a movant must show: "(1) it has a substantial likelihood of success on the merits; (2) irreparable injury will be suffered unless the injunction issues; (3) the threatened injury to the movant outweighs whatever damage the proposed injunction may cause the opposing party; and (4) if issued, the injunction would not be adverse to the public interest." *Jones v. Governor of Fla.*, 950 F.3d 795, 806 (11th Cir. 2020) (citing *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000) (en banc)). "[A]ll of the well-pleaded allegations of [the] complaint and uncontroverted affidavits filed in support of the motion for a preliminary injunction are taken as true." *Elrod v. Burns*, 427 U.S. 347, 350 n.1 (1976).

A temporary restraining order may be imposed "to preserve the court's ability to make a meaningful ruling on the merits," which "often requires preserving the status quo." *W. Ala. Women's Ctr. v. Williamson*, 120 F. Supp. 3d 1296, 1320 (M.D. Ala. 2015). To obtain a temporary restraining order, the movant must show: "(1) a substantial likelihood of ultimate success on the merits; (2) the TRO is necessary to

prevent irreparable injury; (3) the threatened injury outweighs the harm the TRO would inflict on the non-movant; and (4) the TRO would serve the public interest." *Ingram v. Ault*, 50 F.3d 898, 900 (11th Cir. 1995).

These factors strongly support entry of a preliminary injunction in this case. In the event that the Court is unable to make a ruling on the merits of Plaintiffs' preliminary injunction motion before the May 8, 2022 effective date of the Act, these factors also warrant entry of a temporary restraining order because "it is in the public interest to preserve the status quo and give the court an opportunity to evaluate fully the lawfulness of [the Act] without subjecting the plaintiffs, their patients, or the public at large to any of its potential harms." *Planned Parenthood Se., Inc. v. Bentley*, 951 F. Supp. 2d 1280, 1290 (M.D. Ala. 2013).

A. Plaintiffs Will Likely Succeed on the Merits of Their Claims Because the Act Is Unconstitutional.

Plaintiffs have a substantial likelihood of success on the merits of their claims. The Act infringes upon their constitutional rights to parental autonomy and equal protection, violates the right to freedom of speech, and is void for vagueness. It also conflicts with the Affordable Care Act ("ACA"), 42 U.S.C. § 18001, *et seq*. (2010).

1. The Act Infringes on Parental Autonomy by Preventing Parents from Obtaining Essential Medical Care for their Children (Count I).

The Act violates the fundamental right of the Parent Plaintiffs to obtain essential medical care for their children. The Fourteenth Amendment to the United

States Constitution protects parents' rights to make decisions "concerning the care, custody, and control of their children," based on a "presumption" that "fit parents act in the best interests of their children." *Troxel v. Granville*, 530 U.S. 57, 66, 68-69 (2000). This right is "perhaps the oldest of the fundamental liberty interests recognized by this Court." *Id*. at 65; *see also Parham v. J.R.*, 442 U.S. 584, 602 (1979) (collecting cases to demonstrate that the Court has long recognized the importance of parental rights, including *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944), *and Pierce v. Soc'y of the Sisters of the Holy Names of Jesus & Mary*, 268 U.S. 510, 535 (1925)); *May v. Anderson*, 345 U.S. 528, 533 (1953) (recognizing that parental rights are "far more precious . . . than property rights"). Because this right is fundamental, any substantial infringement of parental autonomy is subject to strict scrutiny. *Lofton v. Sec'y of Dep't of Child. & Fam. Servs.*, 358 F.3d 804, 815 (11th Cir. 2004); *see also Troxel*, 530 U.S. at 80 (Thomas, J., concurring).

A parent's ability to seek and obtain appropriate medical treatment to ensure the health and wellbeing of their child is a core aspect of this fundamental right. The Eleventh Circuit has explained that the Due Process Clause prohibits a state, "concerned for the medical needs of a child," from "willfully disregard[ing] the right of parents to generally make decisions concerning the treatment to be given to their children." *Bendiburg v. Dempsey*, 909 F.2d 463, 470 (11th Cir. 1990). "[P]arents have the right to decide free from unjustified governmental interference in matters

concerning the growth, development and upbringing of their children." *Id.* (quoting *Arnold v. Bd. of Educ. of Escambia Cty.*, 880 F.2d 305, 313 (11th Cir. 1989)).

The Act fails constitutional review because it negates, without justification, parents' fundamental right to seek established medical care for their transgender children. Indeed, the Act criminalizes medical care: (1) recommended to the Parent Plaintiffs as appropriate for their children by their medical providers, and (2) recognized by the American Medical Association, American Academy of Pediatrics, American Psychiatric Association, American Psychological Association, Pediatric Endocrine Society, and the Endocrine Society as the only effective treatment for their children. *See Brandt v. Rutledge*, 551 F. Supp. 3d 882, 892 (E.D. Ark. 2021), *appeal docketed*, No. 21-2875 (8th Cir. Apr. 19, 2022) (finding that "Parent Plaintiffs have a fundamental right to seek medical care for their children and, in conjunction with their adolescent child's consent and their doctor's recommendation, make a judgment that medical care is necessary"). The Act prevents parents even from *seeking* expert medical advice by imposing criminal penalties on anyone who "causes" the proscribed treatments to be performed on a transgender minor—language that would encompass consultations with healthcare providers who recommend transition if doing so results in a parent obtaining medical care for their child. SB 184 § 4(a). This categorical, sweeping ban—like any ban on

parents' ability to seek established medical care for a serious medical condition—is unconstitutional.

As set forth below, none of the State's asserted justifications for this intrusion on parental rights has merit. Contrary to the State's assertion, the Act jeopardizes children's health and safety; it does not protect it. *Brandt*, 551 F. Supp. 3d at 893 (holding that a similar Arkansas law likely violated "a fundamental parental right" and likely would fail strict scrutiny because the State could not show that the law served the stated goal of protecting children).

2. The Act Violates Equal Protection by Barring Medical Treatments for Transgender Minors (Count II).

The Act singles out transgender minors in order to deny them medical care, including denying them the very same medications available to non-transgender minors. Because the Act discriminates on the basis of transgender status and sex, heightened scrutiny is required. Because the State's asserted rationales for the ban lack merit, Plaintiffs have a substantial likelihood of proving that the Act violates the Equal Protection Clause.

a. The Act is Subject to Heightened Scrutiny Under Well-Established Precedent.

The Act's discrimination against transgender people is apparent on its face. The Act bans medical care for minors whose "perception of [their] gender or sex . . . is inconsistent with the minor's sex" at birth—*i.e.*, for minors who are transgender.

SB 184 § 4(a). Elsewhere the Act refers to "individuals, including minors, who experience discordance between their sex and their internal sense of identity." *Id.* § 2(2)-(4). The Act's description of its targeted group—those whose perception or internal sense of their sex differs from their sex at birth—coincides exactly with the definition of a transgender person. It matters not that the Act does not use the word "transgender," any more than it would matter if a law criminalizing same-sex intimacy did not use the word "lesbian" or "gay." Under settled law, a statute that classifies based on conduct or characteristics that either define or are closely correlated with a particular group facially discriminates against that group. *See, e.g.*, *Christian Legal Soc'y v. Martinez*, 561 U.S. 661, 689 (2010) (holding that a club's exclusion of people because they engaged in same-sex conduct was discrimination based on sexual orientation); *Lawrence v. Texas*, 539 U.S. 558, 575 (2003) ("When homosexual conduct is made criminal by the law of the State, that declaration in and of itself is an invitation to subject homosexual persons to discrimination . . . ."); *id.* at 583 (O'Connor, J., concurring in judgment) (stating that a law targeting conduct "closely correlated with being homosexual" is "directed toward gay persons as a class"); *cf. Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 270 (1993) ("A tax on wearing yarmulkes is a tax on Jews.").

By discriminating against transgender people, the Act also discriminates based on sex. Without question, the Act singles out transgender minors for disparate

treatment. Both the Supreme Court and the Eleventh Circuit have held that discrimination because a person is transgender is based on sex. *See Bostock v. Clayton Cty.*, 140 S. Ct. 1731, 1741 (2020) (holding that "it is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex"); *Glenn v. Brumby*, 663 F.3d 1312, 1316 (11th Cir. 2011) (holding that "discriminating against someone on the basis of his or her gender non-conformity constitutes sex-based discrimination under the Equal Protection Clause").

Because the Act discriminates based on transgender status and sex, it is subject to heightened scrutiny under the Equal Protection Clause. Federal courts across the country have held that discrimination based on transgender status warrants heightened scrutiny, as it meets the criteria for suspect classification established in *Frontiero v. Richardson*, 411 U.S. 677, 686 (1973): transgender people have suffered a history of discrimination; being transgender is an immutable trait and one that is unrelated to a person's ability to participate in or contribute to society; and transgender people lack the political power to achieve full equality through the political process.[1]

[1] *See, e.g.*, *Whitaker v. Kenosha Unified Sch. Dist. No. 1*, 858 F. 3d 1034, 1051 (7th Cir. 2017); *Smith v. City of Salem*, 378 F.3d 566, 572 (6th Cir. 2004); *Toomey v. Arizona*, No. CV-19-00035-TUC-RM, 2019 WL 7172144, at *5 (D. Ariz. Dec. 23, 2019); *Stone v. Trump*, 400 F. Supp. 3d 317, 355 (D. Md. 2019); *F.V. v. Barron*, 286 F. Supp. 3d 1131, 1145 (D. Idaho 2018); *M.A.B. v. Bd. of Educ. of Talbot Cty.*, 286 F. Supp. 3d 704 (D. Md. 2018); *Board of Educ. of the Highland*

In *Brumby*, the Eleventh Circuit held that discrimination because a person is transgender is discrimination based on sex and warrants heightened scrutiny for that reason. As the court explained: "A person is defined as transgender precisely because of the perception that his or her behavior transgresses gender stereotypes." 663. F.3d at 1316. Accordingly, "discrimination on this basis is a form of sex-based discrimination that is subject to heightened scrutiny under the Equal Protection Clause." *Id*. at 1319.

Whether the Act is analyzed as discrimination based on transgender status or sex, the State, at a minimum, "must show at least that the [challenged] classification serves important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives." *United States v. Virginia*, 518 U.S. 515, 516 (1996) (quotations omitted) (modifications in original). The justification must be "exceedingly persuasive." *Id*. The "burden of justification is demanding, and it rests entirely on the State." *Id*. Neither the State's asserted interest nor the alleged relationship between the interest and the discriminatory classification may "rely on overbroad generalizations." *Sessions v. Morales-Santana*, 137 S. Ct. 1678, 1689, 1692 (2017). Nor may the State "hypothesiz[e] or inven[t]" its interests "*post hoc* in response to litigation"—they

Local Sch. Dist. v. U.S. Dep't of Educ., 208 F. Supp. 3d 850, 874 (S.D. Ohio 2016); *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015); *Adkins v. City of New York*, 143 F. Supp. 3d 134, 139 (S.D.N.Y. 2015).

must be the actual goals the policy was intended to advance at the time it was created. *Id.* at 1696–97 (quoting *Virginia*, 518 U.S. at 533).

b. Defendants Cannot Establish the State's Asserted Interest Serves Important Governmental Objectives or the Act Is Substantially Related to the Achievement of those Objectives.

The Act prohibits parents from obtaining treatments for their children that are the standard of care for gender dysphoria. Decades of evidence support the safety and efficacy of transition, including the use of puberty-blocking medication and hormone therapy, for treating gender dysphoria in adolescents. (Hawkins Decl. ¶ 25; Ladinsky Decl. ¶ 7; Rosenthal Decl. ¶¶ 17, 27-31.) Barring those treatments for transgender youth deprives them of medically necessary care and puts them at serious risk of mental health issues, self-harm, and suicide. *See Brandt*, 551 F. Supp. 3d at 891-92 (finding similar bill banning medical treatment for transgender adolescents did not meet heightened scrutiny review, and "would not even withstand rational basis scrutiny" because "[g]ender-affirming treatment is supported by medical evidence that has been subject to rigorous study" and "[e]very major expert medical association recognizes that gender-affirming care for transgender minors may be medically appropriate and necessary to improve the physical and mental health of transgender people"); *see also* Hawkins Decl. ¶ 46; Ladinsky Decl. ¶ 15; Rosenthal Decl. ¶¶ 45, 55, 57. The Act also increases the likelihood that transgender adolescents will eventually require major surgeries to

reverse bodily changes that could have been avoided by the well-established non-surgical treatments the Act criminalizes. (Rosenthal Decl. ¶ 37.)

The Act purports to advance the objective of protecting transgender minors. Nevertheless, the State's asserted justifications for the Act have no basis in medical science and undermine, rather than advance, the Act's purported goals. They cannot survive even a cursory review, much less the demanding scrutiny required by this case.

i. The treatments are effective and well-established.

Contrary to the Act's assertion, the treatments provided to transgender adolescents with gender dysphoria are effective and based on an established standard of care. As the Act recognizes, there are youth who "experience discordance between their sex and their internal sense of identity," and who, as a result, "experience severe psychological distress," known as "gender dysphoria." SB 184 § 2(2). As the Act also acknowledges, there is an established course of care and treatment for these young people that includes social transition and, where appropriate, puberty blocking medication and hormone therapy. *Id.* § 2(7)-(8).

The Act claims that these treatments are ineffective, but that is incorrect. The Act cites unnamed "studies" that purportedly show that "hormonal and surgical interventions often do not resolve the underlying psychological issues affecting the individual." *Id.* § 2(14). In fact, decades of substantial scientific evidence show that

treatment dramatically improves mental health outcomes for transgender youth, including reducing rates of suicidal ideation and suicide attempts, which are significantly higher among transgender adolescents when compared to their non-transgender peers. (Hawkins Decl. ¶¶ 38, 41; Ladinsky Decl. ¶ 15; Rosenthal Decl. ¶¶ 26, 53-55.)

Transition, including puberty blocking medication and hormone therapy where appropriate, is the standard of care for treating gender dysphoria and has been endorsed by the mainstream medical community in the United States, including the American Medical Association, the American Academy of Pediatrics, and the Endocrine Society, all of which have determined that the care is safe and effective. (Ladinsky Decl. ¶ 7; Rosenthal Decl. ¶ 30.) The Act's assertions that the treatment is "unproven," "poorly studied," and "experimental," SB 184 § 2(11), are unfounded. (Hawkins Decl. ¶¶ 38, 41; Ladinsky Decl. ¶¶ 7-8; Rosenthal Decl. ¶¶ 26, 53-55.)

ii. The treatments are necessary.

The Act's claim that most adolescents with gender dysphoria will "outgrow" their transgender identities is incorrect. *Id.* § 2(4). In contrast, the evidence overwhelmingly shows that transgender adolescents who are appropriately identified, diagnosed, and prescribed treatment continue to live consistent with their gender identity as adults and lead happy and fulfilling lives. (Hawkins Decl. ¶ 26;

Rosenthal Decl. ¶¶ 53-54, 36; Moe Decl. ¶ 16; Koe Decl. ¶¶ 5-7.) In the past, research tracking a wide range of gender-nonconforming children (including tomboyish girls and feminine boys) found that many of these children grew up to identify as lesbian or gay rather than transgender. (Hawkins Decl. ¶ 22.) However, none of these older studies focused on the much smaller, discrete, and clearly identifiable group of children with gender dysphoria whose persistent, insistent, and consistent cross-gender identification continues into adolescence. (*Id.*) More recent research has focused on this specific group of children and found that the likelihood of this group "outgrowing" their transgender identity in adolescence or adulthood is virtually nil. (*Id.*)

The Act also asserts that "[t]he cause of the individual's impression of a discordance between sex and identity is unknown," SB 184 § 2(3), but that is incorrect. In fact, substantial evidence has shown that gender identity has a strong biological foundation and is impervious to external factors. (Rosenthal Decl. ¶ 15.)

Contrary to the Act's assertion, doctors take great care in making a diagnosis of gender dysphoria and follow detailed procedures for both confirming the diagnosis and prescribing a treatment plan, taking a multidisciplinary approach that includes both medical and mental health specialists. The Act incorrectly states that the diagnosis is based "exclusively on the individual's self-report of feelings and beliefs." SB 184 § 2(3). In fact, mental health providers who diagnose youth with

gender dysphoria do so based on a comprehensive evaluation. (Ladinsky Decl. ¶ 10; Rosenthal Decl. ¶ 48; Moe Decl. ¶¶ 6-8.) Any prescribed treatments, including puberty blocking medication and hormone therapy, are undertaken only after thorough assessment and discussion with parents and youth patients, and only after ensuring that all persons involved understand the need for treatment along with any attendant risks, just as in other medical situations where medication may be required to treat a condition. (Ladinsky Decl. ¶¶ 9-11; Rosenthal Decl. ¶¶ 48-51.)

In sum, the Act's claim that the banned treatments are not necessary for the affected children ignores the consensus of medical experts and overwhelming evidence to the contrary. It is inappropriate for the legislature to look at the entire gender-nonconforming youth population, many of whom do not and will never experience gender dysphoria, and bar a medically discrete subset of them from receiving essential medical care. Doing so is like denying life-saving brain cancer treatment recommended by the medical community because most headaches resolve with aspirin. For adolescent patients properly identified as being transgender, a "wait-and-see approach" is harmful and may even be lethal. (Hawkins Decl. ¶ 41; Rosenthal Decl. ¶ 55.)

iii. The treatments are safe.

The Act incorrectly claims that the treatments it bans are unsafe and that transgender adolescents and their parents are unable to assess their risks and benefits.

First, the State's assertion that the treatments are unsafe because they involve off-label use of medications approved by the Food and Drug Administration ("FDA") is unfounded. In fact, many established medical treatments involve off-label uses of FDA-approved medications. (Rosenthal Decl. ¶ 49.) "Off-label" refers to use of medication that has been FDA approved, but not for all condition for which it may be effective. [2] The off-label use of medications for children is quite common and sometimes necessary, because an "overwhelming number of [FDA-approved] drugs" have no FDA-approved instructions for use in pediatric patients.[3]

The American Academy of Pediatrics specifically approves the off-label use of drugs:

> The purpose of off-label use is to benefit the individual patient. Practitioners use their professional judgment to determine these uses. As such, the term "off-label" does not imply an improper, illegal, contraindicated, or investigational use. Therapeutic decision-making must always rely on the best available evidence and the importance of the benefit for the individual patient.[4]

This asserted rationale for the ban also conflicts with the established public policy of this State. On April 1, 2021, the Alabama Senate passed a resolution endorsing the widespread practice of prescribing FDA-approved medications for

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[2] *See* Am. Acad. Pediatrics Comm. Drugs, Off-Label Use of Drugs in Children, 133 Pediatrics 563-67 (2014).

[3] *Id.*

[4] *Id.*

off-label uses to treat COVID-19. In contrast to the alleged justifications for the Act, the Senate Resolution states: "we hereby recognize the sanctity of the physician/patient relationship and that a duly licensed physician should be allowed to prescribe any FDA approved medication for any condition that the physician and patient agree would be beneficial for treatment of the patient without interference by government or private parties." AL SJR 82 (2021). This policy affirms the ability of medical providers to prescribe FDA-approved mediation for "any condition." There is no legitimate reason, much less an important one, to adopt a different rule for medications used to treat transgender patients.

Second, contrary to the Act's assertion, the medications used to treat gender dysphoria, including puberty blockers and hormones, are safe. (Rosenthal Decl. ¶¶ 23, 31, 55.) Puberty-blocking medication has been used for decades to treat a medical condition known as "precocious puberty." (*Id.* ¶ 42.) Hormone therapy is often used to treat medical conditions experienced by adolescents including painful menstruation, amenorrhea, and even serious acne conditions. As the Act itself acknowledges, puberty blocking medication is also used to treat "verified disorder[s] of sexual developments," SB 184 § 4(b)(2), often referred to as intersex conditions. Although no medication can be shown to have zero risks, puberty blocking medication and hormones are considered very safe and well within acceptable risk factors for approved medication for minors. (Rosenthal Decl. ¶¶ 23. 31, 55.)

To the extent there are low-level risks, as there are with any medication, Alabama can offer no justification why puberty blocking medication and hormone therapy should be banned for use by transgender minors as "unsafe" but permitted for treatment of minors with other medical conditions. If the State believed these treatments to be unsafe, it would have banned them for all minors, not just the Transgender Plaintiffs. As the Eastern District of Arkansas found in *Brandt*, this insistency strongly suggests that the State's "goal in passing [the Act] was not to ban a treatment" but rather "to ban an outcome [the provision of supportive care to transgender minors] that the State deems undesirable." *Brandt*, 551 F. Supp. 3d at 891. The Act violates the Equal Protection clause under even the lowest standard of review. *Id*. (finding Arkansas' "health concerns regarding the risks of gender transition procedures . . . pretextual" because Arkansas did not prohibit the same procedures "for all patients under 18 regardless of gender identity"); *Eisenstadt v. Baird*, 405 U.S. 438, 454-55 (1972) (holding law that barred prescription of contraceptives to unmarried people violated the Equal Protection Clause because the law provided "dissimilar treatment for married and unmarried persons who are similarly situated").

The Act's claim that transgender adolescents and their parents are unable to assess the risks of these treatments, *see* SB 184 § 2(10), is similarly arbitrary and without support. As discussed previously, doctors who prescribe puberty blocking

medication or hormone therapy do so only after ensuring that the young person and their parents understand both the risks and benefits of the treatments and are able to make an informed choice, as doctors do when they prescribe any medication. (Hawkins ¶ 36; Ladinsky ¶¶ 9-10; Rosenthal Decl. ¶¶ 47-51.) Alabama law acknowledges that minors fourteen and older are generally able to consent to medical treatment. ALA. CODE § 22-8-4. There is no reason to impose a different rule simply because the minors are transgender.

iv. Minors who stop taking puberty blocking medication or hormone therapy will resume puberty in their birth sex.

The Act also mischaracterizes the effects of puberty blocking medication and hormone therapy. Contrary to the unsupported assertion in the findings, if an adolescent stops taking puberty blocking medication or hormone therapy, the production of endogenous hormones and puberty in the child's birth sex will resume. (Rosenthal Decl. ¶¶ 38, 40.). That is a primary reason why the Plaintiffs are so distressed about the law: Without the treatment they need, their physical development will revert to that associated with their birth sex.

To be sure, promoting the health and safety of minors is an important governmental interest. The Act, however, undermines, rather than promotes, that goal. Barring transgender minors from safe, effective, and established medical care determined to be necessary by their medical providers will destroy lives, including

those of the minor Plaintiffs in this case. Alabama cannot demonstrate that the Act promotes health and safety in even a rational, much less a substantial, way. Accordingly, the Plaintiffs are likely to prevail on their claim that the Act violates the Equal Protection Clause.

3. Plaintiffs Are Likely to Succeed on the Merits of Their First Amendment Claim (Count IV).

The Act also violates the First Amendment by prohibiting any "person," including physicians, healthcare professionals, or even parents, from engaging in speech that would "cause" a transgender minor to receive medical treatment for gender dysphoria. By the Act's plain terms, prohibited speech would include, among many other things: (1) a doctor detailing the benefits of medical treatment for gender dysphoria or expressing the professional opinion that a young person would likely benefit from such treatment, if such discussions result in the minor obtaining treatment; (2) a doctor or therapist referring a patient to an out-of-state provider who can offer medical care; (3) a parent facilitating or expressing support for their child's transition, or any other speech by a parent that results in a minor obtaining medical treatment, such as consenting to treatment; (4) a transgender adolescent engaging in discussions or receiving information that leads them to undergo transition-related care; and (5) a minister or religious counselor engaging in speech that leads to the minor obtaining care. By barring such speech, the Act prevents any person in the State of Alabama from speaking about medically accepted treatments for gender

dysphoria based on the content of those conversations. As a content-based and viewpoint discriminatory regulation of speech, the Act is subject to strict scrutiny, which it fails.

Courts ordinarily apply strict scrutiny when analyzing the constitutionality of content or viewpoint-based restrictions on speech. *See, e.g.*, *Reed v. Town of Gilbert*, 576 U.S. 155, 171 (2015); *Wollschlaeger v. Governor*, 848 F.3d 1293, 1308 (11th Cir. 2017). Content-based laws "target speech based on its communicative content." *Reed*, 576 U.S. at 163. If enforcement authorities must "examine the content of the message that is conveyed" to know whether the law has been violated, a restriction is content-based. *McCullen v. Coakley*, 573 U.S. 464, 479 (2014). "Content-based regulations are presumptively invalid." *R.A.V. v. City of St. Paul*, 505 U.S. 377, 382 (1992).

Prohibiting parents, healthcare providers, and others from engaging in speech that would "cause" a transgender young person to receive medical treatment for gender dysphoria is a content-based regulation, as the content of the speech—support of medical care—drives whether it was the "cause" of a minor obtaining treatment. It is also a viewpoint-based restriction because only speech that encourages medical care for the minor is targeted; speech that forbids or expresses disapproval of such medical care is not punished. *Brandt*, 551 F. Supp. 3d at 893 (finding that similar Arkansas statute was "a content and viewpoint-based regulation

because it restricts healthcare professionals only from making referrals for 'gender transition procedures,' not for other purposes"); *see also Conant v. Walters*, 309 F.3d 629, 637 (9th Cir. 2002) (invalidating policy that punished doctor-patient discussions concerning medical marijuana and holding that "the policy does not merely prohibit the discussion of marijuana; it condemns expression of a particular viewpoint, i.e., that medical marijuana would likely help a specific patient"). Such speech regulations require application of strict scrutiny, which the Act cannot withstand.

To survive First Amendment review, content-based restrictions on speech must be "narrowly tailored to serve compelling state interests." *Reed*, 576 U.S. at 163. "It is rare that a regulation restricting speech because of its content will ever be permissible." *United States v. Playboy Ent. Grp., Inc*., 529 U.S. 803, 818 (2000).

The Act cannot satisfy this demanding test. First, preventing individuals from speaking, and minors from discussing or hearing about medically necessary care does not advance Alabama's stated interest in health and safety. The Act claims to further an interest in protecting minors, yet disregards the long-standing and well-established treatment of gender dysphoria recommended by every major medical association. No court has ever held that a state advances a compelling interest by denying minors—a vulnerable group—medical treatment that is deemed necessary, safe, and effective under the relevant medical standard of care. The State's claimed

interests collapse under strict scrutiny. *See Wollschlaeger*, 848 F.3d at 1317 (holding that state's asserted interest in protecting public health by prohibiting doctors from asking patients about firearm ownership could not satisfy heightened scrutiny where "the applicable standard of care encourages doctors to ask questions about firearms").

Second, the Act is not "narrowly tailored" to advance any asserted interest in health and safety. It prohibits speaking about certain treatments only with respect to transgender youth with gender dysphoria while allowing discussion or recommendations of the same or similar treatments for non-transgender youth for any other purpose or medical condition. Such "[u]nderinclusiveness raises serious doubts about whether the government is in fact pursuing the interest it invokes, rather than disfavoring a particular speaker or viewpoint." *Brown v. Ent. Merchants Ass'n*, 564 U.S. 786, 802 (2011).

Third, the Act cannot withstand strict scrutiny because it is not the "least restrictive means of achieving a compelling state interest." *McCullen*, 573 U.S. at 478. Banning every "person" in Alabama from engaging in an entire category of protected speech—speech that is consistent with established standards of medical care and with the Parent Plaintiffs' view of what is best for their own children's health and wellbeing—is not a constitutionally permissible means of protecting health and safety. The State cannot show that its enactment of "provisions broadly

restricting truthful speech based on content" are the least restrictive means available to achieve a compelling need. *Wollschlaeger*, 848 F.3d at 1316.

Lacking a narrowly tailored means to achieve any compelling or even legitimate interest, the Act's restrictions on speech cannot satisfy even rational basis review, much less strict scrutiny. Plaintiffs have a substantial likelihood of prevailing on their free speech claim.

4. The Act Is Unconstitutionally Vague (Count V).

Under the Due Process Clause, a criminal statute like the Act is void for vagueness if it fails to "define the criminal offense with sufficient definiteness that ordinary people can understand what conduct is prohibited" and encourages "arbitrary and discriminatory enforcement" by the government. *Kolender v. Lawson*, 461 U.S. 352, 357 (1983); *see also Papachristou v. City of Jacksonville*, 405 U.S. 156, 162 (1972) (holding all persons "are entitled to be informed as to what the State commands or forbids") (quoting *Lanzetta v. New Jersey*, 306 U.S. 451, 453 (1939)).

Section 4(a) of the Act states that "no person shall . . . cause any of the following practices to be performed upon a minor" and criminalizes any such act as a felony. Yet, the Act fails to provide *any* standard to determine what an individual must do to "cause" a treatment "to be performed upon a minor." *See Kolender*, 461 U.S. at 358.

"Cause" has an incredibly broad definition: "To bring about or effect." Black's Law Dictionary (11th ed. 2019); *cf. United States v. Eckhardt*, 466 F.3d 938, 944 (11th Cir. 2006) (directing courts to consider, among other things, "dictionaries" and the "common and generally accepted meaning" of words when considering vagueness of a statute).

Therefore, the Act, as worded, could subject anyone who is aware of, refers to, discusses, talks about, recommends, or expresses an opinion about a transgender minor's healthcare to a class C felony and up to ten years imprisonment, no matter how indirect the involvement, so long as the speech or behavior has *any* effect on a minor taking a prohibited medication to treat gender dysphoria. For example, the Act could impose criminal liability on a doctor or therapist in Alabama who recommends that a transgender adolescent start or continue puberty blocking medication or hormones. It could impose criminal liability on a pastor, like Rev. Eknes-Tucker, who counsels parents to seek medical care supporting their transgender children. It could impose criminal liability on a school nurse who dispenses a puberty-blocking medication to an adolescent, or a pharmacist who fills a prescription for estrogen or testosterone for a minor—even if the nurse or pharmacist did not know the child was taking the medication to treat gender dysphoria. *See City of Chi. v. Morales*, 527 U.S. 41, 55 (1999) (finding criminal

statute that "contains no *mens rea* requirement" and "infringes on constitutionally protected rights" to be "subject to facial attack" for vagueness).

Due to this vagueness, the Act encourages arbitrary enforcement and fails to describe what one must do to avoid criminal liability. *See Lanzetta*, 306 U.S. at 453 ("No one may be required at peril of life, liberty or property to speculate as to the meaning of penal statutes.").

B. The Affordable Care Act Preempts the Act Because the Act Mandates Sex Discrimination by Healthcare Providers (Count III).

The Act is preempted by Section 1557 of the ACA. When a federal law and a state law conflict, the state law is preempted. *See, e.g.*, *Taylor v. Polhill*, 964 F.3d 975, 981 (11th Cir. 2020) (citing *Hillsborough Cty. v. Automated Med. Labs., Inc*., 471 U.S. 707, 712 (1985)). For example, states may not impose criminal penalties or "hold a civil defendant liable under state law for conduct federal law requires." *Armstrong v. Exceptional Child Ctr., Inc*., 575 U.S. 320, 326 (2015). Federal courts are empowered to "issue an injunction upon finding the state regulatory actions preempted." *Id.*

Federal courts recognize three categories of preemption: (1) express preemption; (2) field preemption; and (3) conflict preemption. *See Fla. State Conf. of N.A.A.C.P. v. Browning*, 522 F.3d 1153, 1167 (11th Cir. 2008). This case involves the third category, conflict preemption. "Conflict preemption . . . arises in instances

where (1) 'compliance with both federal and state regulations is a physical impossibility,' or (2) 'the challenged state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'" *Fresenius Med. Care Holdings, Inc. v. Tucker*, 704 F.3d 935, 939 (11th Cir. 2013) (quoting *Arizona v. United States*, 567 U.S. 387, 399 (2012) (citations and internal quotation marks omitted)). The Act is preempted because compliance would force covered health care providers to violate Section 1557. Because compliance with both statutes is impossible, and because enforcement of the Act would thwart the fundamental purpose of Congress in prohibiting sex discrimination by covered healthcare providers, federal law preempts the Act.

The Act prohibits Alabama doctors from providing medical care to transgender minors. But Section 1557 of the ACA prohibits such sex discrimination by health care providers receiving federal funds, including plaintiff doctors and other providers from whom plaintiff children receive their care. Section 1557 provides that no individual shall "be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance" on the basis of sex. 42 U.S.C. § 18116(a). As explained above, the Act's ban and criminalization of medications and surgeries only when provided to a transgender individual is discrimination based on sex. *See Bostock,*

140 S. Ct. at 1741; *Brumby*, 663 F.3d at 1316. Violators of Section 1557 risk losing federal funding, civil enforcement proceedings brought by the federal government, civil lawsuits, debarment from doing business with the federal government, False Claims Act lawsuits, and criminal penalties. *See*, *e.g.*, 20 U.S.C. § 1682; *see also Jolley v. Riverwoods Behav. Health, LLC*, No. 1:21-CV-00561-WMR, 2021 WL 6752161, at *5-6 (N.D. Ga. Aug. 30, 2021) (slip op.) (denying motion to dismiss private claim of Section 1557 ACA discrimination based on transgender status); *Hammons v. Univ. of Md. Med. Sys. Corp.*, 551 F. Supp. 3d 567, 592 (D. Md. 2021) (finding plaintiff pled Section 1557 discrimination where hospital refused to perform hysterectomy to treat gender dysphoria).

The Transgender Plaintiffs receive their medical care from providers who receive federal financial assistance and funding and who are subject to the non-discrimination provisions of Section 1557 of the ACA. *See* 42 U.S.C. § 18116(a). (*See also* Koe Decl ¶ 13.) In addition, the Healthcare Provider Plaintiffs are subject to Section 1557 of the ACA because they receive federal financial assistance as providers of medical care for transgender beneficiaries of Alabama Medicaid. (*See id.* ¶ 13.)

Healthcare Provider Plaintiffs cannot comply with both Section 1557 of the ACA and the Act. They are put in the impossible position of complying with Section 1557 by providing medical care to transgender minors consistent with the standard

of care, and risking criminal penalties under the Act, or complying with the Act and being subject to federal enforcement proceedings and private lawsuits for discrimination under Section 1557. *See* Letter from Kristen Clarke, Assistant Attorney General at U.S. Dep't of Justice Civil Rights Div., to State Attorneys General (Mar. 31, 2022), *available at* https://www.justice.gov/opa/press-release/file/1489066/download (reminding state attorneys general that Section 1557 of the Affordable Care Act prohibits state laws that discriminate against transgender people). As such, the ACA preempts the Act's requirement that healthcare providers must deny certain types of medical care to transgender minors based on their transgender status. The Act puts healthcare providers in an impossible position and also contravenes the overall goal of the ACA—to broaden access to healthcare in the United States—as well as the specific purpose of Section 1557 to prevent discrimination in the provision of healthcare. *See King v. Burwell*, 576 U.S. 473, 478-79 (2015). Because the Act conflicts with the ACA, it is preempted by federal law and may not be enforced.

IV. The Act Will Cause Immediate, Irreparable Harm to Plaintiffs.

Without the injunctive relief sought, the Act will cause Plaintiffs to suffer serious irreparable harms.

First, if the Act is not enjoined, the Parent Plaintiffs will be forced to helplessly watch the harm to their children unfold because the Act deprives them of

the fundamental constitutional right to obtain essential medical care for their children. *See Brandt*, 551 F. Supp. 3d at 892-93 (finding parent plaintiffs demonstrated irreparable harm where act banning transition-related care for minors infringed on their fundamental right to parent their children). Like other parents, these Parent Plaintiffs want to be able to care for their children—to get their children the medical care doctors have told them, and they have seen for themselves, is essential to their children's ability to thrive. The Act inflicts serious, irreparable harm by barring the Parent Plaintiffs from acting in the best interests of their children in an area that lies at the heart of parental responsibilities and rights.

Second, the Act also inflicts irreparable harm by depriving the Transgender Plaintiffs of necessary medical care for a serious medical condition. This denial will cause irreversible and harmful physical changes and irreparable mental harm, including the reemergence of gender dysphoria which untreated will predictably cause them to suffer anxiety, depression, and severe psychological distress. Denial of medically necessary medical care is sufficient to show immediate and irreparable harm. *See, e.g.*, *Bowen v. City of New York*, 476 U.S. 467, 483-84 (1986) (finding denial of benefits caused irreparable injury by exposing plaintiffs to "severe medical setback[s]" or hospitalization); *Gayle v. Meade*, -- F.Supp.3d --, No. 20-21553-CIV, 2020 WL 3041326, at *20-21 (S.D. Fla. June 6, 2020) (holding that increased likelihood of serious illness constitutes an irreparable injury); *Flack v. Wis. Dep't of*

Health Servs., 331 F.R.D. 361, 373 (W.D. Wis. 2019) (denying coverage for medical treatment for gender dysphoria is irreparable harm); *Karnoski v. Trump*, No. C17-1297-MJP, 2017 WL 6311305, at *9 (W.D. Wash. Dec. 11, 2017) (finding that denial of "transition-related medical care" constituted irreparable harm).

Without the essential treatment Zachary needs, he will resume going through an unwanted female puberty that conflicts with his male identity, and he will suffer devastating and irreversible physical and psychological consequences as a result. (Zoe Decl. ¶¶ 11-13.) Michael, whose mental health providers have recommended that he be assessed for medical treatment of gender dysphoria, will be unable to obtain that care, which will exacerbate his gender dysphoria and force him to undergo harmful and unwanted physical changes that will be devastating to his physical and mental health. (Boe Decl. ¶¶ 9, 15.) Christopher and Allison, who both are currently on hormone therapy and thriving as a result, will be cut off from this essential care. (Noe Decl. ¶¶ 15, 17-18; Poe Decl. ¶¶ 21-22.) Their bodies will undergo extremely distressing and unwanted physical changes that will cause them to suffer severe emotional and psychological distress. (*See* Noe Decl. ¶¶ 12, 18; Poe Decl. ¶¶ 23-25.) These harms are serious, irreparable, and potentially life-threatening. (Ladinsky Decl. ¶¶ 15-16; Rosenthal Decl. ¶¶ 37, 44-45, 55, 57; *see also* Moe. Decl. ¶¶ 15-16.)

As the district court found in *Brandt* when enjoining a similar Arkansas law, barring transgender youth from essential medical care forces them to "undergo endogenous puberty," causing them to "live with physical characteristics that do not conform to their gender identity, putting them at high risk of gender dysphoria and lifelong physical and emotional pain." 551 F. Supp. 3d at 892; *see also Campbell v. Kallas*, No. 16-CV-261-JDP, 2020 WL 7230235, at *8 (W.D. Wis. Dec. 8, 2020) (slip op.) (finding plaintiff demonstrated "irreparable injury" required for an injunction where plaintiff "continues to suffer from gender dysphoria, which causes her anguish and puts her at risk of self-harm or suicide").

Third, enforcement of the Act will also inflict irreparable harm on Drs. Koe and Moe, who will face the ever-present threat of criminal prosecution and penalties if they continue to provide medically necessary and appropriate referrals and treatments to their minor transgender patients, and who will be put to the untenable choice of either risking arrest or harming their patients. *See Brandt*, 551 F. Supp. 3d at 891-92 (finding healthcare provider plaintiffs proved irreparable harm when Arkansas medical ban would force them to "choos[e] between breaking the law and providing appropriate guidance and interventions for their transgender patients").

And finally, enforcement of the Act will irreparably harm Rev. Eknes-Tucker by criminalizing his pastoral speech. "The loss of First Amendment freedoms, for

even minimal periods of time, unquestionably constitutes irreparable injury." *Elrod v. Burns*, 427 U.S. 347, 373 (1976) (plurality opinion).

As the Eleventh Circuit has explained, constitutional violations constitute irreparable harm when they cannot "be compensated for by monetary damages." *Ne. Fla. Chapter of Ass'n of Gen. Contractors v. City of Jacksonville*, 896 F.2d 1283, 1285 (11th Cir. 1990); *see also Cate v. Oldham,* 707 F.2d 1176, 1189 (11th Cir. 1983) (holding that the directly penalizing free speech constitutes irreparable injury for purposes of a preliminary injunction). No amount of money can compensate for the Act's infringement on a parents' right to seek and obtain essential medical care for their child. Nor can money compensate for the imposition of criminal penalties on parents' First Amendment right to seek information and recommendations from healthcare providers, on doctors' constitutionally protected freedom to share their opinions and expertise with their patients, or on a pastor's rights to counsel families consistent with his faith-based beliefs. The enforcement of the Act in violation of these fundamental rights inflicts irreparable harm and warrants entry of a preliminary injunction.

V. Injuries to Plaintiffs Outweigh Any Damage to the State, Which Has No Interest in Enforcing an Unconstitutional Law.

The serious irreparable harms that Plaintiffs will experience if the Act takes effect outweigh any countervailing government interest. When "the nonmovant is the government, . . . the third and fourth requirements [for an injunction]—'damage

to the opposing party' and 'public interest'—can be consolidated." *Otto v. City of Boca Raton*, 981 F.3d 854, 870 (11th Cir. 2020); *see also Nken v. Holder*, 556 U.S. 418, 435 (2009) (same). Moreover, there is no "legitimate interest in enforcing an unconstitutional ordinance." *Otto*, 981 F.3d at 870; *see also KH Outdoor, LLC v. City of Trussville*, 458 F.3d 1261, 1272 (11th Cir. 2006).

The balance of the equities strongly favors an injunction here. On the one side, the State is seeking to enforce an injurious, unconstitutional, and discriminatory law. In sharp contrast, the Act will impose significant irreparable harms on transgender young people, their parents, healthcare providers, and faith leaders like Rev. Eknes-Tucker. Plaintiffs will be forced to watch their children suffer the harm of losing the medical care they need and of experiencing the mental anguish and pain of untreated gender dysphoria. The Transgender Plaintiffs will abruptly lose essential medical care, be forced to undergo irreversible physical changes, and suffer intense suffering and distress. The Healthcare Provider Plaintiffs will be forced to choose between imprisonment and inflicting harm on vulnerable patients, as they cannot provide the medical care consistent with the recognized standard of care that they believe to be in their patients' best interest.

To be sure, the balance of the equities strongly favors an injunction here. An injunction would maintain the status quo while Plaintiffs pursue their claims. Plaintiffs can continue to meet their children's medical needs, transgender young

people can continue to receive recommended, medically necessary treatment for their gender dysphoria, healthcare providers can continue to treat their patients without fear of prosecution, and faith leaders can continue to counsel families consistent with their religious beliefs while this case is litigated.

VI. CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that this Court enjoin the State from implementing Act while this lawsuit is pending. Plaintiffs further request the Court to enter a temporary restraining order if the Court is unable to rule on Plaintiffs' preliminary injunction motion before May 8, 2022, when the law is scheduled to go into effect.

Respectfully submitted this 21st day of April, 2022.

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CERTIFICATE OF SERVICE

I certify that on this 21st day of April, 2022, I filed the foregoing with the Clerk of Court. I further certify that I will cause a copy of this Memorandum and accompanying Motion and Exhibits to be served along with a copy of the Summons and Complaint by delivering a copy to the following Defendants, or to their respective agents who are authorized by law to receive service of process, pursuant to Fed. R. Civ. P. 4:

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EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER; BRIANNA BOE, individually and on behalf of her minor son, MICHAEL BOE; JAMES ZOE, individually and on behalf of his minor son, ZACHARY ZOE; MEGAN POE, individually and on behalf of her minor daughter, ALLISON POE; KATHY NOE, individually and on behalf of her minor son, CHRISTOPHER NOE; JANE MOE, Ph.D.; and RACHEL KOE, M.D.,

Plaintiffs,

v.

KAY IVEY, in her official capacity as Governor of the State of Alabama; STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama; DARYL D. BAILEY, in his official capacity as District Attorney for Montgomery County; C. WILSON BAYLOCK, in his official capacity as District Attorney for Cullman County; JESSICA VENTIERE, in her official capacity as District Attorney for Lee County; TOM ANDERSON, in his official capacity as District Attorney for the 12th Judicial Circuit; and DANNY CARR, in his official capacity as District Attorney for Jefferson County,

Defendants.

Civil Action No. 2:22-cv-184-LCB

Hon. Liles C. Burke

DECLARATION OF LINDA A. HAWKINS, PH.D., LPC IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER & PRELIMINARY INJUNCTION

I, Linda A. Hawkins, Ph.D., M.S.Ed., LPC, declare as follows:

1. I submit this expert declaration based upon my personal knowledge.

2. If called to testify in this matter, I would testify truthfully based on my expert opinion.

Qualifications and Experience

3. I am a Licensed Professional Counselor with a M.S.Ed. in Psychological Services from the University of Pennsylvania in 1998, and a Ph.D. in Human Development and Human Sexuality from Widener University in 2009, specializing in working with children and adolescents experiencing gender dysphoria and their families. A true and correct copy of my Curriculum Vitae is attached hereto as **Exhibit A**.

4. I have over two decades of experience in supporting lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth and their families, both in private practice and through my work with hospitals and clinics. During that time, I have individually worked with more than 4,000 LGBTQ children, adolescents, and families from around the world.

5. In January 2014, I helped found and co-direct the Gender & Sexuality Development Program at The Children's Hospital of Philadelphia, which now operates from two clinics: Philadelphia, Pennsylvania and Voorhees, New Jersey. As Program Director, I oversee the care of nearly 3,000 families and field an average of

twenty new referrals a week. I also lead and participate in research for developing best care practices for LGBTQ children and their families, train health care and mental health providers on best care practices, establish gender-affirming hospital policies, and advise local, regional, and national organizations as they create and update guidelines for the care of transgender and gender-expansive children, youth, and their families. This includes direct trainings and policy review with schools, churches, social service agencies, mental health centers, and juvenile correction centers and insurance companies.

6. In January 2018, I helped found the Advanced Training Program in Affirmative Therapy for Transgender Communities, which is a year-long national professional training course for therapists to train them in supporting transgender clients across their clients' lifespans, that now has sites based in Seattle, Washington and Philadelphia, Pennsylvania. I have served as the Founder and Director since the program's inception, which includes both teaching duties and supervising the eight employees who implement the training and supervise the program on a daily basis. The American Psychological Association, U.S. Professional Association of Transgender Health, American Counseling Association, and American Association of Sexuality Educators, Counselors and Therapists are currently considering endorsing the program.

7. My recent publications include *Experience of Chest Dysphoria and Masculinizing Chest Surgery in Transmasculine Youth*, Pediatrics, 147(3) (2021); *Transgender Youth Experiences with Implantable GnRH Agonists for Puberty Suppression*, Liebert (https://doi.org/10.1089/trgh.2021.0006) (2021); *Sexual and Gender Minority Adolescents: Meeting the Needs of Our LGBTQ Patients and Their Families*, Clinical Pediatric Emergency Medicine, 20(1), 9–16 (2019); *Sexual Orientation/Gender Identity Cultural Competence: A Simulation Pilot Study*, Clinical Simulation in Nursing, 16, 2–5 (2018); *Barriers to Care for Gender Non-Conforming Youth: Perspectives of Experienced Care Providers, Transgender Youth and Their Parents*, Journal of Adolescent Health, Vol. 62, Issue 2 (2018); *Effective Treatment of Depressive Disorders in Medical Clinics for Adolescents and Young Adults Living with HIV: A Controlled Trial*, Journal of Acquired Immune Deficiency Syndrome, 71(1), 38–46 (2017); *Policy Perspective: Ensuring Comprehensive Care and Support for Gender Nonconforming Children and Adolescents*, Transgender Health, 1(1), 75–86 (2016); and *Creating Welcoming Spaces for Lesbian, Gay, Bisexual and Transgender (LGBT) Patients: An Evaluation of the Healthcare Environment*, Journal of Homosexuality, 63(3), 387–93 (2016). I have also authored chapters of textbooks, including "Sexual Disorders and Transgender Health" in *Fundamentals in Consultation Psychiatry: Principles and Practice*, Eds. Lavakumar, M., Rosenthal, L., & Rabinowitz, T. Nova Medicine & Health: New

York, NY (2019). A listing of my publications is included in my Curriculum Vitae in **Exhibit A**.

8. I belong to a number of professional organizations and associations relating to (i) the overall mental health and well-being of all children, youth and their families; (ii) the health and well-being of children and adolescents, including those who are transgender; and (iii) to appropriate medical treatments for transgender individuals. For example, since 2005, I have been a member of the World Professional Association for Transgender Health ("WPATH"), an international multidisciplinary professional association to promote evidence-based care, education, research, advocacy, public policy and respect in transgender health. I was also elected as a Fellow of the College of Physicians of Philadelphia, invited to join based on my local, regional, national, and international contributions to the medical and mental health and wellness of transgender and gender non-binary children and youth, as well as my contributions to the education of medical professionals as part of this care. A complete list of my involvement in various professional associations is located in my Curriculum Vitae in **Exhibit A**.

9. From 2010-present, I have served as an Editorial Reviewer for Academic Pediatrics and the Society for the Scientific Study of Sexuality.

10. I have previously testified two times at trial or in deposition as an expert witness.

11. My opinions contained in this declaration are based on: (i) my years of experience as a Licensed Counselor and PhD training in treating transgender patients, including children, adolescents and young adults; (ii) my knowledge of the peer-reviewed research, including my own, regarding the treatment of LGBTQ patients and those suffering from gender dysphoria; and (iii) my review of the various declarations submitted in support of the motions. I generally rely on these types of materials when I provide expert testimony, and they include the documents specifically cited as supportive examples in particular sections of this declaration. The materials I have relied on in preparing this declaration are the same type of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

12. I was provided with and reviewed the following case-specific materials: (i) the expert declaration of Stephen Rosenthal, M.D. ("Dr. Rosenthal Decl."), and (ii) Senate Bill 184, as enacted ("the Act").

13. I have not met or spoken with the Plaintiffs or their parents for purposes of this declaration. My opinions are based solely on the information that I have been provided by Plaintiffs' attorneys as well as my extensive experience studying gender dysphoria and treating transgender patients.

14. I am being compensated at an hourly rate for the actual time that I devote to this case, at the rate of $300 per hour for any review of records, preparation

of reports or declarations, and deposition and trial testimony. My compensation does not depend on the outcome of this litigation, the opinions that I express, or the testimony that I provide.

Gender Identity Development and Gender Dysphoria

15. Because a person's gender identity is unknowable at birth, doctors assign sex based on the appearance of a newborn's external genitalia. For most people, that assignment also turns out to be a consistent reflection of their gender identity. However, for transgender people, their assigned sex does not match their gender identity.

16. Gender identity is a person's innate, inner sense of belonging to a particular gender, such as male or female.

17. Medical, mental health and human development research has repeatedly shown that gender identity is hard wired and a core component of human identity. Every person has a gender identity. Dr. Rosenthal's declaration provides a comprehensive overview of the research demonstrating that gender identity has strong biological ties. (Dr. Rosenthal Decl. at ¶¶ 14-17.)

18. A person's gender identity is not a personal decision, preference, or belief. Like nontransgender people, transgender people do not simply have a "preference" to live consistent with their gender identity; trying to live as a gender they are not feels viscerally wrong and can cause a range of psychological outcomes

from minor distress to overwhelming daily anxiety and depression that can culminate in thoughts of self-harm or death.

19. A key milestone of child development is a child becoming aware of their gender identity. My declaration will focus on that process and the psychological distress young people experience when their assigned sex and gender identity do not match.

20. Children typically become aware of their gender identity between the ages of three and five years old. During these young years, individuals will often gravitate toward toys, clothing, activities, and peer relationships that most typically align with their gender identity. At the same time, those children are also surrounded by gender rules, regulations and expectations in their families, the media, and community. Children assigned male at birth are typically rewarded for following the male-based expectations set out for them and the children assigned female at birth are equally rewarded for following the female-based expectations set out for them, regardless of the child's gender identity.

21. Transgender individuals who become aware in childhood that those expectations do not match with who they are often begin to express their cross-gender identity to their family members and caregivers. The statements and actions transgender children use to communicate their cross-gender identity differ significantly from age-appropriate imaginative play. Transgender children are

insistent, persistent, and consistent over time in their cross-gender identification. Transgender children will also manifest psychological distress as a result of the mismatch between their assigned sex and their gender identity if they are not allowed to live consistent with their gender identity.

22. This sets the experience of transgender children apart from non-transgender children. While non-transgender children may also experience some gender exploration, and some girls will be "tomboys" and some boys will live as feminine boys, the intensity and persistence of the cross-gender identification that transgender children express is of a different order. Historically, earlier studies included a wide range of gender nonconforming children, rather than differentiating between transgender and non-transgender children, and also suffered from other serious methodological flaws that make them unreliable. Today, based on current scientific knowledge and clinical practice, researchers and clinicians are much better equipped to differentiate transgender from non-transgender children and adolescents. Recent studies have found that, when following the standard of care for diagnosing gender dysphoria, the rate of "desistance" for transgender adolescents who are properly diagnosed, evaluated, and treated is virtually nonexistent.

23. A significant proportion of transgender children do not have the ability to clearly understand, state or share the distress they are experiencing. Those children can experience a wide range of psychological distress from difficulty

sleeping to anxiety at school or severe depression and may not fully realize that this distress is linked to being transgender. Over time, their inability to understand the root of their distress and/or to express themselves further exacerbates their psychological distress.

24. Yet another significant proportion of young transgender children may have had an underlying feeling of not fully aligning with the sex they were assigned at birth, but felt "good enough" being supported and perceived as a female identified as a tomboy or a feminine presenting gay male. However, as puberty starts and a young person begins to experience the physical changes associated with their birth sex including developing secondary-sex characteristics (*e.g.*, breast development, menstruation, testicular and penile expansion, and deepening of voice) these youth experience intense distress that cannot be explained as simply being upset about puberty. That distress is caused by gender dysphoria, which is exacerbated by puberty for youth who are transgender, not simply gender nonconforming. These youth share a strong and real awareness of their gender identity not as a female identified as a tomboy, but as male, and not as a feminine male, but a female.

25. Gender Dysphoria is the diagnosis characterized by the severe and unremitting emotional pain resulting from the incongruity between a person's assigned sex and their gender identity. It is a serious condition and is listed in the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-5") of the American

Psychiatric Association and has been for decades. Because Gender Dysphoria also has significant implications for a transgender young person's physical health that require medical care, there is also a companion diagnosis in the World Health Organization's International Classification of Diseases (ICD-10). Major medical and behavioral health associations recognize the validity and seriousness of the condition of gender dysphoria and support its treatment consistent with established standards of care. These include the American Medical Association, the Endocrine Society, the American Academy of Pediatrics, the American Psychological Association, the American Psychiatric Association, National Association of Social Workers, and others.

Standards of Care for Working with Transgender Children

26. When loved, supported, and treated consistent with their gender identity by their parents and caretakers and in their social, medical and educational environments, transgender children—like all children—can thrive, grow into healthy adults and have the same capacity for happiness, achievement, and contribution to society as others. For transgender children and youth, that means supporting them to live in a manner consistent with their gender identity.

27. Getting treatment for Gender Dysphoria and ensuring that a transgender child is in an environment that does not undermine that treatment are critical to a transgender child's healthy development and well-being. For young transgender

children, the treatment of Gender Dysphoria consists of social transition, which involves changes that bring the child's outer appearance and lived experience into alignment with the child's gender identity. Changes often associated with a social transition include changes in clothing, name, pronouns, hairstyle, and updating government-issued identity documents to reflect the child's new name and correct the sex listed on those documents so that others interact with them in a manner that affirms and supports their gender identity.

28. Research and clinical experience have shown that social transition for a child with Gender Dysphoria improves that child's mental health and greatly reduces the risk that the child will experience anxiety, depression and possibly engage in self-harming behaviors. *See Kristina Olson, et al., Mental Health of Transgender Children who are Supported in Their Identities*, 137 Pediatrics 1 (2016). In fact, longitudinal studies demonstrate that undergoing a social transition before puberty often provides tremendous and immediate relief because there are few, if any, observable physical differences between boys and girls at that age.

29. A social transition is often eventually coupled with other treatments for Gender Dysphoria once a young person enters adolescence including puberty blockers and hormone therapy to bring a person's body into alignment with their gender identity. The availability and effects of those treatments are discussed in detail in Dr. Rosenthal's declaration. (Dr. Rosenthal Decl. ¶¶ 32-55.) As with social

transition those treatments occur within a context of treatment and assessment by qualified professionals, often in a single multidisciplinary setting meaning that a patient's multiple providers (endocrine, primary care, mental health specialist) all work in consultation and coordination with one another to provide care for the patient.

30. Mental health counseling can have a tremendous positive effect on a patient's mental health. Not only can counseling reduce a young person's psychological distress, but it can help reduce their reliance on harmful coping strategies, if not replace them all together. I have seen many patients make significant progress through counseling to address many, but not all, areas of distress a transgender child or youth may be experiencing with their own identity as well as coping with how others around them may be reacting to their transgender identity.

31. For transgender young people approaching or going through puberty, however, counseling by itself is not sufficient to fully manage their Gender Dysphoria. The physical changes associated with puberty greatly exacerbate a transgender young person's psychological distress because their bodies are becoming more incongruent with their gender identity every day. More importantly, counseling is unable to stop those changes from occurring, nor can it help bring a patient's body into alignment with their gender identity. For many transgender youth, medical care is crucial and vital for survival.

The Role of Mental Health Providers in Assessing Necessity of Medical Treatments for Gender Dysphoria

32. When a child or adolescent experiencing Gender Dysphoria starts to see a mental health provider such as myself, that provider's first objective is assessment, including diagnosis. As with any assessment, the provider must gather a detailed history of the patient and their psychological distress surrounding their gender identity, including its sources and manifestations. To appropriately conduct that assessment, the mental health provider must draw from their professional training and experience in working with transgender young people, exercise professional judgment, and tailor the assessment to each individual patient and their family. The number of sessions that assessment requires will vary greatly depending on the patient's presentation and the complexity of the issues the patient is navigating.

33. In addition to meeting with the patient and family, this assessment process typically includes gathering and reviewing additional information from the child's Primary Care Provider, local therapist and psychiatrist and any additional adult professionals who are part of the patient's care team. Without this thorough and comprehensive assessment, a mental health provider could not accurately diagnose a patient with Gender Dysphoria and provide the recommendations for treatment and care.

34. Once the mental health provider has confirmed that the patient is experiencing Gender Dysphoria, the provider develops a treatment plan, which can

include referrals to medical providers for treatments like puberty-blocking medications and hormone therapy.

35. Over the course of their initial assessment—and subsequent treatment—mental health providers will engage their patients in many discussions about the aspects of the patient's life and appearance that exacerbate their Gender Dysphoria. The purpose of those conversations is two-fold: identify the areas where the patient needs to develop resilience and coping strategies to minimize the effects of their Gender Dysphoria; and evaluate the mental health benefits of future social changes and medical treatment. For example, those discussions may reveal that a transgender patient's distress about the onset of puberty is impairing their ability to engage in peer relationships or routine self-care (*e.g.,* avoiding showering), as well as impairing their ability to focus at school. The mental health provider can then work with the patient to develop psychological and social strategies to reducing the functional limitations caused by the Gender Dysphoria. While this level of care can prove fully beneficial for some young people diagnosed with Gender Dysphoria, in other cases the treatment plan strongly indicates that puberty-blocking medications is necessary to prevent that patient's mental health from deteriorating at the onset of puberty.

36. If the patient and their family decide to pursue medical treatment, the mental health provider will build on those discussions to also assess the patient's

appropriateness and readiness for that treatment. As mentioned above, the appropriateness of any medical treatment is determined by a multidisciplinary team of expert mental and medical care providers. A patient's readiness to begin a particular course of medical treatment requires an evaluation of the patient's understanding of the goals and potential limitations of the contemplated treatment. For example, for puberty-blocking medication, the provider will gauge the patient's ability to comprehend the effects of puberty on their body and mental health. An integral part of that discussion is evaluating a patient's grasp of the consequences of stopping those physical changes from occurring and alternatives to puberty-blocking treatment. And, in cases of the addition of hormone therapy in adolescence, the review of physical impact, including benefits and limitations, is explored over multiple meetings with the patient and parents.[1] The provider will have those discussions with the patient and their parents both individually and together. As with the initial diagnosis, the amount of time required to complete this evaluation will depend on numerous factors including the length of their existing therapist-patient relationship and the complexity of the issues facing that patient.

[1] *See*, *e.g.*, *"This Wasn't a Split-Second Decision": An Empirical Ethical Analysis of Transgender Youth Capacity, Rights, and Authority to Consent to Hormone Therapy*, Clark, BA, Bioethical Inquiry (2021) https://doi.org/10.1007/s11673-020-10086-9.

37. The mental health provider will then document the results of their assessment in a letter to the patient's treating physician. The letter details the provider's diagnostic analysis as well as any professional opinions regarding the benefits of and readiness for the contemplated treatment. The medical provider uses that letter as one piece of their own independent assessment. It is not uncommon for a medical provider to contact the patient's mental health provider to discuss the details of the letter.

Medical Treatment for Gender Dysphoria is Critical to the Mental Health of Transgender Youth

38. Scientific literature and clinical experience consistently find that, like social transition, medical treatment for Gender Dysphoria offers significant psychological benefit to transgender young people. For example, one longitudinal study found that transgender young adults who received the full range of medical and mental health treatments for their gender dysphoria had a mental health profile that was indistinguishable from their non-transgender peers. Annelou L.C. de Vries, et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014). Medical treatments for gender dysphoria are effective because they keep a transgender person's body in alignment with their gender identity, either by stopping that incongruence from growing or by changing the person's body to be more congruent with their gender identity, which in turn help reduce a person's Gender Dysphoria.

39. Conversely, however, the denial of medical treatment will severely hinder a transgender young person's development and well-being. Even if not initially visible to the public, the physical changes associated with puberty widen the incongruence between a transgender young person's body and their gender identity. The permanence of those physical changes can result in distress that is significant and acute because the changes brought on by puberty become constant triggers for Gender Dysphoria, such as monthly menstruation, chest development, deepening of voice and unwanted erections.

40. As puberty progresses, those physical changes become more obvious and will undermine a transgender young person's ability to live in a manner consistent with their gender identity. Their appearance will cause them to be repeatedly referred to by their birth sex, which is different than their gender identity. The incongruence between their gender identity and appearance will also subject them to ridicule, harassment, and discrimination. In either situation, a transgender young person will experience that mistreatment as a rejection of their core self and identity, which will further exacerbate their Gender Dysphoria.

41. If left unaddressed, as under the wait-and-see approach, a transgender young person is likely to develop co-occurring mental health conditions, such as major depression, anxiety or obsessive-compulsive disorders, eating disorders, self-harm, and thoughts of suicide. Transgender young people can also experience

difficulties focusing on schoolwork, building and maintaining friendships, among other serious functional limitations.

42. Those harms are exponentially compounded for a transgender young person living at the intersection of minority identities based on the layered ways in which peers and adults can stigmatize identified differences in race, ethnicity, religion/faith and socioeconomic status. Multiply marginalized children and youth face vastly higher levels of anxiety and depression that are more likely to lead to self-harm and even death by suicide. In the last few years, as individuals in these multiply marginalized communities are coming under direct and indirect attack from political and religious groups, these children are becoming gravely aware that they are not safe in their own neighborhoods and are constantly exposed to negative messages that profoundly state that they do not matter, are not important parts of our community, and otherwise do not belong.

43. Chronic exposure to those levels of sustained stress results in persistent surges of cortisol in the brain for children and youth. This leads to a wide array of short and long-term detrimental consequences, all of which can permanently affect development, emotional, physical and mental health, and quality of life. For example, research has shown that it leads to increased difficulty in differentiating between threatening and safe situations, impaired short-term and long-term memory, struggles with decision-making and attention, and issues with mood control, even in

adulthood. Studies have also shown that chronic stress in childhood and adolescence results in a higher likelihood of developing a myriad of physical health issues, including diabetes, heart disease, and cancer.

44. Once an area of clear and consistent stress and distress has been identified for any child, it should be addressed in a way that provides clear, consistent and safe relief. This is vital based on the research on both the negative health impact of chronic stress/distress on human bodies as well as the clear, safe and consistent guidelines for relieving this stress and distress for transgender children and youth.

Conclusion

45. Criminalizing the provision of medical treatment for Gender Dysphoria will inflict immeasurable harm on transgender young people throughout Alabama that will have long-lasting implications for the mental health of this already vulnerable population and the many family members who support them. Transgender young people will have proven effective, life sustaining medical care dangerously delayed between five and ten years to obtain what are considered time-sensitive medical treatments for gender dysphoria. Not only will their mental health decompensate during that time, but their ability to treat and manage their Gender Dysphoria will be greatly diminished with some body changes being irreversible. For many transgender children, the inability to access essential time-sensitive medical treatment will result in irreparable damage to their physical and

psychological health.

46. Those harms will significantly compound the inability of transgender young people to live in a manner consistent with their gender identity due to body changes that negate their ability to keep private, for those who wish to do so, the deeply personal fact that they are transgender. Additionally, the social and educational harms resulting from profound and debilitating bullying and harassment of transgender children in local social settings (clubs, sports, after school programs, churches) and school settings will frequently result in out of school placements, online schooling and/or complete removal from academic efforts overall. All of these negative outcomes in childhood have far-reaching and exponentially impacting effects on overall health and wellbeing, typically resulting in a significant increase in anxiety, depression, self-harm and death by suicide.

47. Despite claiming to protect transgender children, the Act will have the exact opposite effect.

This declaration was executed this 17th day of April, 2022.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Linda Hawkins, Ph.D., M.S.Ed., LPC

EXHIBIT A

Curriculum Vitae

Name: **Linda Aline Hawkins, PhD, LPC**
Address: 7153 Anderson Street, Philadelphia, PA 19119
Phone: **215-280-7128**
Email: drlahawkins@gmail.com

Education & Licensure

Licensed Professional Counselor, Pennsylvania – PA #006287 - March, 2012
Ph.D., Human Development & Human Sexuality, Clinical Counseling Focus – Widener University, Chester, PA, October, 2009
Linda Lehnert Memorial Award – Excellence in Academics & Research (4.0 GPA)
Distinguished Dissertation Nomination – Gender Identity Development among Gender Variant Adolescents: A Qualitative Analysis
M.S.Ed., Psychological Services – University of Pennsylvania, Philadelphia, PA, August, 1998
B.S., Speech and Hearing Sciences – University of Washington, Seattle, WA, June, 1993

Current Employment

Founder & Director: Gender & Sexuality Development Program, The Children's Hospital of Philadelphia, Philadelphia, PA, January 2014 to present.
This clinic was one of the nation's first four pediatric gender clinics to support children and youth who are gender non-conforming, gender explorative and/or transgender.
Accomplishments as part of achieving this include:

- Developed the business plan and founded the Philadelphia clinic at the Hospital in January, 2014 and expanded to include a Voorhees, NJ clinic in January of 2020.
- Established needed gender affirming policies within the Hospital to support the clinic patients and families, including updating the employee non-discrimination policy and the patient bill of rights.
- Currently running a clinic of nearly 1500 families within first three years of opening; fielding 10-15 referrals weekly.
- Securing nearly 100% rate of insurance coverage for puberty blockers through advocacy and education between hospital physicians and insurance adjustors.
- Secured multiple internal and externa funding for patient and family needs, including full funding for the family support group, giving library of books to support family exploration and childhood learning on gender, and training support.
- Supervise and coordinate staff and scheduling.
- Lead and participate in research development as it pertains to the development of best care practices for our patients and families.
- Assure the Hospital and all affiliates are performing at the highest level possible in the overarching support for all LGBTQ staff, employees and providers.
- Providing state and regional trainings for health care and mental health providers.
- Mentoring hospitals nationwide in developing gender affirming care clinics with practices, policies, training and advocacy.
- Advising local, regional and national guidelines for the care of transgender and gender expansive children, youth and their families.

Family Services Specialist: Department of Patient & Family Services, The Children's Hospital of Philadelphia, January, 2014 to present.
Goal is to provide on-going assessment of the Hospital policies and practices to assure at every point of contact with patients, families and staff, LGBT individuals are treated with respect, competence and the best practices in health care and employment experience.

- Conducting annual training seminars and lectures throughout the CHOP Network and affiliates to increase their LGBT competence in supporting patients and families.
- Conducted numerous Grand Rounds presentations and private sessions to assist multiple hospitals to both increase their LGBT patient and family competence, as well as increase specific competence with transgender child/youth patient care.
- Establishing first pediatric plans for Transgender Child & Youth Policy & Practice.
- As a result of all of the above, successfully supported the Hospital in achieving the Human Rights Campaign Endorsement as a Leader in LGBT Healthcare Equality for The Children's Hospital of Philadelphia from 2014 to present..

Director & Trainer: Advanced Training in Affirmative Therapy for Transgender Communities, Widener University, January, 2018 to present.
Designed and implemented a one-year professional training program for mental health providers based at Widener University. Expanded to bi-coastal in-person offering in Philadelphia and Seattle, shifted to online during pandemic.

- Designed year-long curriculum that includes two, in-person weekends and weekly on-line supervision as well as monthly readings.
- Supervise 6 training staff to implement the above training and supervision needs.
- Develop promotion materials to reach a national audience of potential participants.

Additional Program Development & Management Experience
Interim Director, Gender Affirming Care Clinic: Johns Hopkins All Children's Hospital, St. Petersburg, FL, September 2019 to September 2021. Accomplishments: Completed comprehensive needs assessment of the hospital network to determine existing strengths and areas for growth in providing gender affirming care. Completed comprehensive needs assessment of patient and family care needs. Developed and implemented program expansion plan resulting in the first fully staffed, interdisciplinary care program for transgender and gender nonbinary children, youth and families in the state of Florida.

Interim Director, Center for Gender Affirming Care: Rady Children's Hospital, San Diego, CA, January 2017 to January 2019. Accomplishments: Completed comprehensive needs assessment of the hospital network to determine existing strengths and areas for growth in providing gender affirming care. Completed comprehensive needs assessment of patient and family care needs. Developed and implemented program expansion plan resulting in the rebuilt interdisciplinary care program for transgender and gender nonbinary children, youth and families in San Diego.

Director of Counseling Services: The Attic Youth Center, Philadelphia, PA, May, 2004 to September, 2011. Accomplishments: Expanded program from 2 therapists to 7 therapists with psychiatry partnership and insurance funding. Supervised therapists (MSW, MEd, PsyD and

PhD level clinicians) to provide complete counseling and psychosocial services to sexual and gender minority youth (ages 14-24 years old). Built collaboration with Community Behavioral Health (CBH) to ensure funding for services. Developed annual student training program. Clinical team awarded the Association of Gay & Lesbian Psychiatrists Honor of Mental Health for Youth in 2011. Supervisors: Carrie Jacobs, PhD, Executive Director and Cornelius Furgesson, PhD, Licensed Psychologist.

Program Manager, HIV Counseling and Testing: Adolescent Medicine, The Children's Hospital of Philadelphia, Philadelphia, PA, October, 2004 to March, 2008. Accomplishments: Organized and coordinated all adolescent sexual health and HIV counseling within the Hospital network. Expanded program from 2 testing sites to 9 sites including multiple community events throughout Philadelphia. Developed testing protocols that met and exceeded best practice for testing with youth and young adults. Led strategic grant writing to fund existing and expanded programming, securing annual funding for 4 full time health educators/testers and partial supervision/management salaries. Supervisor: Christine Ambrose, LSW, Program Manager.

Program Coordinator: The Injury Free Coalition for Kids of Philadelphia, The Children's Hospital of Philadelphia, Philadelphia, PA, February, 1999 to February, 2004. Accomplishments: Developed a community based coalition of medical, education, public health, government, and faith based leaders to address the crisis of unintentional injury to children in West and Southwest Philadelphia. Led research and interventions to assess needs, build partnerships and strategize solutions with and for the community. Provided training and guidance to MD, MPH, SW, MEd, and PhD students interested in community based wellness and public health promotion. Led strategic grant writing to secure initial and sustainable funding for core coalition staff and all projects through sources including: Robert Wood Johnson Foundation, DHHS, Ronald McDonald House Philadelphia, Philadelphia Foundation, PEW Charitable Trust, and multiple local funding groups. Successfully funded a $300,000 playground through grassroots, faith-based and competitive matching funds. Supervisors: Flaura Winston, MD, PhD, Center for Pediatric Injury Prevention, and Marla Vanore, MSEd, Trauma Program Manager.

Additional Clinical Experience

Private Practice: Hawkins LifeWorks LLC, Philadelphia, PA, September, 2012 to January, 2014. *Private practice offering clinical support to children and youth who identify as LGBTQ and their families (no new clients as of 2014). Currently offering training for schools, churches and community agencies. Also providing clinical supervision to trainees seeking clinical training needs in these specific areas.*

- Supported numerous children, youth and families in their mental health care needs.
- Supervised 12 clinical trainees, to date, in their clinical training hours.
- Continue to clinically supervise 4 trainees seeking licensure and a dozen clinicians within private practice.
- Providing trainings at colleges and hospitals throughout the nation to increase their competency in supporting the needs of LGBT children, youth and families.

Lead Mental Health Counselor: Adolescent HIV Initiative, Adolescent Medicine, The Children's Hospital of Philadelphia, Philadelphia, PA, February, 2004 to December, 2013. Duties:

Providing one on one, couples, family, and group counseling to youth diagnosed with HIV. Train and supervise intern, extern and practicum students in clinical counseling. Build partnerships with community-based counseling and psychiatry services to provide comprehensive seamless care to patients. Lead and assist in grant writing to fund psychosocial support team members (social work, nursing and wellness counselor) with successful awards from the AIDS Activities Coordinating Office (AACO), NIH, NIMH, and DHHS. Supervisor: Tracy DiFonzo, LCSW, Program Manager and Benoit Dube, MD, Psychiatrist.

Adolescent Counselor: The Attic Youth Center, Philadelphia, PA, February, 1999 to December, 2006. Duties: Providing one on one, couples, and group counseling to gay, lesbian, bisexual, transgender, and questioning youth. Supervisor: Cornelius Furgesson, PhD, Licensed Psychologist

Adolescent Counselor: The Open Door, Philadelphia Community Health Alternatives, Philadelphia, PA, March, 1999 to March, 2001. Duties: Providing one on one, couples, and group counseling to gay, lesbian, bisexual, transgender, and questioning youth. Supervisor: Phillip Rutter, PhD, Program Director.

Child Clinical Therapist Intern: Philadelphia Child Guidance Center – Department of Child & Adolescent Psychiatry at the Children's Hospital of Philadelphia, Philadelphia, PA, September, 1997 to May, 1998. Duties: Conducted individual and group counseling with behaviorally challenged children and their families. Collaborated with multidisciplinary team to devise and implement treatment plans. Supervisor: Dr. Brenda Pemberton, Director.

Additional Teaching Experience

Adjunct Associate Professor: Widener University Center for Human Sexuality Studies, Chester, PA, Summer, 2008 to Spring, 2017.

The Center for Human Sexuality Studies at Widener University is the only nationally accredited program in sexuality education and clinical sexuality training in the United States. Students come from across the nation and Canada to train within this program.

Courses Taught as Lead Instructor:

- *HSED 645 – Sexual Minorities*
- *HSED 624 - Education and Training Methods for the Clinical Sexologist*
- *HSED 695 & 696 - Practicum Supervision (2 semesters)*
- *HSED 588(elective) – Clinical Implications of HIV*
- *HSED 588(elective) - Sexually Transmitted Infections & HIV/AIDS*
- *HSED 593 - Behavioral Foundations of Human Sexuality*
- *HSED 645 - Sexual Minorities*
- *ED652 - Group Process and Dynamics*
- *PY 622 – Trauma, Advocacy & Social Justice*
- *CFTP 511 – Introduction to Sex Therapy: Concepts in Human Sexuality*

Consistently achieving exceptional ranking in all course evaluations, on both content, communication and expertise.

Awarded the 2015 Widener Points of Pride Award – awarded annually to the faculty member for exceptional scholarship in the field of sexuality to support the students, faculty and overall profession in the field.

Adjunct Professor: Arcadia University Masters in Psychology Program, Glenside, PA, Fall, 2013 to Spring, 2014. Duties: Design, instruct and evaluate courses for Masters level students. Supervisor: Dr. Eleonora Bartoli, Program Director.

Additional Research Experience

Study Coordinator & Behavioral Study Interventionist: Adolescent Trials Network (ATN), The Children's Hospital of Philadelphia, Philadelphia, PA, January, 2008 to December, 2013. Duties: Implement NIH funded research protocols as designed and designated through the ATN. As coordinator, assure all subject selection, protocol procedure, documentation, data entry, and quality assurance meets and exceeds study requirements. As interventionist, assure all aspects of intervention procedures meet the dynamic needs of the subjects and the study protocol. Supervisor: Mary Tanney, RN, MPH, Research Nurse.

2010 – 2013: Study Interventionist & Coordinator for *Treatment for Depression Among HIV-Infected Youth – (ATN 080)*

2008 – 2013: Study Coordinator for *Neurocognitive Assessment in Youth Initiating HAART, A Multi-Center Study of the Adolescent Medicine Trails Network for HIV/AIDS Interventions (ATN 071)*

2009 – 2012: Study Coordinator & Supervisor for *Mindfulness Approaches to Increasing Wellness Among Youth Living with HIV – Partnership with The Johns Hopkins School of Medicine*

2008 – 2010: Study Interventionist & Coordinator for *Integrated Treatment of Alcohol and/or Marijuana Abuse for HIV-Infected Youth – Focus Groups, Phase I & Phase II (ATN 069)*

2008 – 2009: Co-Investigator for *Sexual Health Risk Among Adolescent and Young Adult African Americans Living with HIV who have Sex with Men – Adolescent Initiative Study, The Children's Hospital of Philadelphia*

2005 - 2006: Primary Investigator for *Internal Validation of OraQuick Advance Rapid HIV 1-2 Antibody Test Kit on Oral Fluids Compared to Standard ELISA Serum Screening – Point of Care Testing, The Children's Hospital of Philadelphia*

2004 – 2005: Co-Investigator for *Post-Traumatic Stress Reactions in HIV-positive Youth: An exploratory study to identify life stressors and impact of diagnosis - Adolescent Initiative Study, The Children's Hospital of Philadelphia*

Peer-reviewed Publications

2021 Hobson, B., Lett, E., **Hawkins, L.**, Swediman, R., Nance, M., & Dowshen, N. Transgender Youth Experiences with Implant GnRH

Agonists for Puberty Suppression. *Transgender Health*, 16 Sep 2021https://doi.org/10.1089/trgh.2021.0006

2021 Experiences of Chest Dysphoria and Masculinizing Chest Surgery in Transmasculine Youth. Mehringer, J., Harrison, J., Quain, K., Sea, J., **Hawkins, L**., & Dowshen, N. *Pediatrics*, 147(3).

2020 Schlupp, A., Dowshen, N., **Hawkins, L.,** & Stallings, V. The Prevalence and Patterns of Food and Beverage Restriction for Bathroom Avoidance in Transgender and Gender-Diverse Youth: A Retrospective Chart Review. *Journal of Adolescent Health Research Poster Symposia*, 66(2), S29.

2019 Libby, B., Miller, V., Regan, K., Gruschow, S., Hawkins, L., & Dowshen, N. Communication of Acceptance and Support In Families Who Have Gender-Variant Youth. *Journal of Adolescent Health*, 64(2), S101-S102.

2019 House, H., Gaines, S., **Hawkins, L**., Sexual and Gender Minority Adolescents: Meeting the Needs of Our LGBTQ Patients and Their Families. *Clinical Pediatric Emergency Medicine*, 20(1), 9-16.

2018 Dowshen, N., Gruschow, S., Taylor, S., Lee, S., & **Hawkins, L**. Barriers to Care for Gender Non-Conforming Youth: Perspectives of Experienced Care Providers, Transgender Youth and Their Parents. *Journal of Adolescent Health*, 62(2), S42.

2018 Hickerson, K., **Hawkins, L.**, & Hoyt-Brennan, A. Sexual Orientation/Gender Identity Cultural Competence: A Simulation Pilot Study. *Clinical Simulation in Nursing*, 16, 2-5.

2017 Brown, L., Kennard, B., Emslie, G.,…**Hawkins, L**. Effective Treatment of Depressive Disorders in Medical Clinics for Adolescents and Young Adults living with HIV: A controlled trial. *Journal of Acquired Immune Deficiency Syndrom*, 71(1), 38-46.

2016 Contributing author. Supporting & Caring for Transgender Children. *Human Rights Campaign*.

2016 Dowshen, N., Lee, S., Castillo, M., **Hawkins, L.**, & Barg, F. Barriers and Facilitators to HIV Prevention, Testing, and Treatment among Young Transgender Women. *Journal of Adolescent Health*, 58(2, Supp), S81-82.

2016 Dowshen, N., Meadows, R., Bymes, M., **Hawkins, L.,** Eder, J., & Noonan, K. Policy Perspective: Ensuring comprehensive care and support for gender nonconforming children and adolescents. *Transgender Health*, 1(1), 75-86. http://online.liebertpub.com/doi/pdfplus/10.1089/trgh.2016.0002

2016	McClain, Z., **Hawkins, L.A.**, & Yehai, B. Creating Welcoming Spaces for Lesbian, Gay, Bisexual, and Transgender (LGBT) Patients: An Evaluation of the Healthcare Environment. *Journal of Homosexuality*, 63(3).
2015	Dowshen, N., Meadows, R., Bynes, M., **Hawkins, L.,** Eder, J., & Noonan, K. Ensuring Comprehensive Care and Support for Gender Non-Conforming Children and Adolescents. *Policy Lab: Evidence To Action*, Fall 2015.
2014	Kennard, B., Brown, L., T., **Hawkins, L**., Risi, A., Radcliffe, J., Emslie, G., Mayes, T., King, J., Foxwell, A., Buyukdura, J., Bethel, J., Naar-King, S., Safran, S., Xu, J., Lee, S., Garvie, P., London, C., Tanney, M., Thornton, S., and the Adolescent Trials Network for HIV/AIDS Interventions. Development of Health and Wellness CBT for Individuals with Depression and HIV: Feasibility and Acceptability. Journal of Cognitive & Behavioral Practice, pp 237-246.
2011	Radcliffe, J., Beidas, R., **Hawkins, L**. & Doty, N. Trauma and Sexual Risk Among Sexual Minority African American HIV Positive Young Adults. *Traumatology*, June 2011.
August, 2010	Radcliffe, J., Doty, N., **Hawkins, L.A.**, Smith, C. Beidas, R., and Rudy, BJ. Stigma and Sexual Health Risk in HIV-Positive African American Young Men who have Sex with Men. AIDS Patient Care and STDs, 24(8).
May, 2010	Radcliffe, J., Beidas, R., **Hawkins, L.A.**, and Doty, N. Trauma and Sexual Risk Among Sexual Minority African-American HIV+ Young Adults. Traumatology. May 7, 2010 as doi:10.1177/1534765610365911
June, 2009	Valenzuela, J., Buchanan, C., Radcliffe, J., Ambrose, C., **Hawkins, L.A.,** Tanney, M. and Rudy, BJ. Transition to Adult Services Among Behaviorally Infected Adolescents with HIV – A Qualitative Study. Journal of Pediatric Psychology, Advanced Access published June 19, 2009
June, 2008	Mollen, CJ, Lavelle, J., **Hawkins, LA**, Ambrose, C. and Rudy, BJ. Description of a Novel Pediatric Emergency Department-Based HIV Screening Program for Adolescents. *AIDS Patient Care and STDs*, 22(6), 505-512.
July, 2007	Radcliffe, J, Fleisher, C.L., **Hawkins, LA**, Tanney, M, Kassam-Adams, N, Ambrose, C, and Rudy, BJ. Posttraumatic Stress and Trauma History in Adolescents and Young Adults with HIV. *AIDS Patient Care and STDs*, 21(7), 501-508.

June, 2004	Posner,J., **Hawkins, LA**, Garcia-Espana, F., & Durbin, D. A randomized controlled trial of a home safety intervention based in an emergency department setting. *Pediatrics*, 113(6), 1603-1608.
September, 2004	Nance, ML, **Hawkins, LA**, Branas, CC, Vivarelli-O'Neill, C, and Winston, FK. Optimal driving conditions are the most common injury conditions for child pedestrians. *Pediatric Emergency Care*, 20(9), 569-573.
December, 2001	Kodman-Jones, C., **Hawkins, L.**, Schulman, S.L. Behavioral characteristics of children with daytime wetting. *Journal of Urology*, 166(6);2392-2395.

Book chapters and other publications

2019	Dube, B, & **Hawkins, L.A** (2019). Sexual Disorders and Transgender Health. Chapter 11 in Fundamentals in Consultation Psychiatry: Principles and Practice. Eds Lavakumar, M., Rosenthal, L., & Rabinowitz, T. Nova Medicine & Health: New York, NY
2018	Hickerson, K., **Hawkins, LA**., Hoyt-Brennan, A. (2018). Sexual Orientation/Gender Identity Cultural Competence: A simulation pilot study. Clinical Simulation in Nursing, 16, 2-5.
2016	McClain, Z., **Hawkins, LA**, Yehia, BR. (2016). Creating Welcoming Spaces for Lesbian, Gay, Bisexual and Transgender (LGBT) Patients: An evaluation of health care environment. Journal of Homosexuality, 63(3), 387-393.
2016	**Linda A. Hawkins,** Nadia Dowshen, Susan Lee. The Bathroom Debate: A legal argument that is causing a public health crisis, PolicyLab, Children's Hospital of Philadelphia http://policylab.chop.edu/blog/bathroom-debate-legal-argument-causing-public-health-crisis
2015	Ensuring Comprehensive Care and Support for Gender Non-Conforming Children and Adolescents. http://policylab.chop.edu/evidence-action-brief/ensuring-comprehensive-care-and-support-gender-non-conforming-children-and
2015	Simms, S., & **Hawkins, L.A.**, *Families with Chronic Medical Issues*, book chapter in Browning, S (Ed.), Contemporary Families: Translating Research into Practice. Routledge: New York, NY.

2014	**Hawkins, L.A.**, & Ginsburg, K.R., *Core Principles in Communicating with Adolescents*, in Ginsburg KR and Kinsman SB. Reaching Teens: Wisdom from Adolescent Medicine. Elks Grove Village IL; American Academy of Pediatrics; (A Textbook and Video Product)
2014	Dowshen, N., **Hawkins, L.A.**, Arrington-Saunders, R., Reirden, D.H., & Garofalo, R, *Sexual and Gender Minority Youth*, in Ginsburg KR and Kinsman SB. Reaching Teens: Wisdom from Adolescent Medicine. Elks Grove Village IL; American Academy of Pediatrics; (A Textbook and Video Product)
2014	Dowshen, N., **Hawkins, L.A.**, Arrington-Saunders, R., Reirden, D.H., & Garofalo, R, *HIV-Infected Youth*, in Ginsburg KR and Kinsman SB. Reaching Teens: Wisdom from Adolescent Medicine. Elks Grove Village IL; American Academy of Pediatrics; (A Textbook and Video Product)
2014	Radcliffe, J., **Hawkins, L.A.,** & Buchanan, C. Pediatric HIV, book chapter in Clinical Practice of Pediatric Psychology: Cases and service delivery. Guilford Press.

Professional Organizations & Appointments

2019 – Present	College of Physicians of Philadelphia - Fellow
2018 – Present	Pennsylvania Transgender Task Force – Appointed by Dr. Rachel Levine and Governor Tom Wolfe - Member
2017 – Present	Human Rights Campaign Transgender Working Group - Member
2012 – Present	American Counseling Association – Member
2012 – Present	Pennsylvania Counseling Association - Member
2011 – 2017	Sexuality Information and Education Council of the United States – Board Member
2010 – Present	Academic Pediatrics – Reviewer
2010 – Present	Society for the Scientific Study of Sexuality – Member & Reviewer
2008 – 2010	Equality Advocates (now Equality Pennsylvania) – Board Member
2005 – Present	World Professional Association for Transgender Health (formerly HBIGDA) - member
2005 – Present	Society for the Scientific Study of Sexuality – Member
2005 – Present	American Association of Sexuality Educators, Counselors and Therapists – Member

Invited Lectures

February 2020	Supporting Transgender, Gender Non-Conforming and Gender Expansive Children & Youth Department of Social Work Johns Hopkins All Children's Hospital, St. Petersburg, FL
January 2020	It Starts With You: Promoting LGBTQ Competence among Colleagues

	Lecture Series: Office of Diversity & Inclusion The Children's Hospital of Philadelphia, Philadelphia, PA
October 2019	Expanding Care for All to Include Transgender Children & Youth Keynote: New Jersey Physicians Advisory Committee, Cherry Hill, NJ
September 2019	Supporting Transgender Children & Youth Keynote: Cooper Pediatrics Group, Moorestown, NJ
September 2019	Collaborating for Care: Models of Gender Clinic Collaboratoin & Mentorship Across the US National Conference, United States Professional Association for Transgender Health (USPATH), Washington, DC
July 2019	Building Knowledge, Skills and Community to Support Transgender Communities: A training program for mental health professionals 2019 Trans Wellness Conference, Philadelphia, PA
July 2019	Non-Binary Youth: Clinical Complexities of Supporting Gender Creativity in a Binary World Gender Spectrum Conference, Moraga, CA
June 2019	Transforming Systems: Creating the Ideal Trans Care Experience National Conference, Canadian Professional Association for Transgender Health (CanPATH), Toronto, Canada
December 2018	Foundational Aspects of Gender Development & Gender Identity Emergence across the Lifespan Hospital of the University of Pennsylvania, Philadelphia, PA
September 2018	Understanding Gender Identity & Development in 2018: Professional, parental and personal perspectives The College of Physicians of Philadelphia, Philadelphia, PA
February 2018	Creating the Ideal LGBTQ Patient & Family Experience: From Policy to Practice Boston Children’s Hospital, Boston, MA
February 2017	Creating Systemic Change for Transgender Children & Youth: Establishing a multidisciplinary pediatric practice that supports patients and families within a hospital network and beyond National Conference, United States Professional Association for Transgender Health (USPATH), Los Angeles, CA
March 2016	Pennsylvania College of Physicians

	Supporting Transgender, Gender Non-Conforming and Gender Expansive Children & Youth, Philadelphia, PA
March 2016	Children's Hospital Association National Conference Creating an Inclusive Experience for LGBT Patients & Families: Policy to Practice, New Orleans, LA
September 2015	Supporting Transgender, Gender Non-Conforming and Gender Expansive Children & Youth Keynote speaker, MSW Field Faculty Orientation University of Pennsylvania School of Social Policy & Practice
April, 2015	Understanding Transgender & Gender Expansive Children & Youth Psychiatry Grand Rounds Baystate Medical Center, Springfield, MA
March, 2015	Creating an Inclusive Experience for LGBT Patients & Families ***Human Rights Campaign Endorsed Training* Family Centered Care Grand Rounds The Children's Hospital of Philadelphia, Philadelphia, PA
March, 2015	Supporting Gender Non-Conforming Children & Youth in Primary Care CHOP at Virtua Care Center, Voorhees, NJ
March, 2015	Creating a Supportive Campus for All Students William Penn Charter School, Middle School, Philadelphia, PA
December, 2014	Understanding & Supporting Your Transgender Patient Family Practice Resident Training Hospital of the University of Pennsylvania, Philadelphia, PA
December, 2014	LGBT Inclusive Research Practice ***Human Rights Campaign Endorsed Training* PROSPER Research Training Children's Hospital of Philadelphia Research Institute, Philadelphia, PA
December, 2014	Creating Child Abuse Investigations Inclusive of Sexual Orientation & Gender Identity Philadelphia Children's Alliance Annual Conference, Philadelphia, PA
November, 2014	Affirmative Clinical Work with Gender-Expansive Children & Youth: Common Issues & Considerations Gender Spectrum East Conference, Baltimore, MD
October, 2014	Supporting Lesbian, Gay, Bisexual and/or Transgender Individuals & Families

	Montgomery Behavioral Health Provider Training Series, Norristown, PA
September, 2014	Creating a Supportive Campus for All Students William Penn Charter School, Upper School, Philadelphia, PA
June, 2014	Multidisciplinary Best Practice: Medical, Mental Health & Legal Perspectives 13th Annual Trans Health Conference, Philadelphia, PA
June, 2014	Supporting Non-Binary Children & Youth: A partnership between mental health and medical providers 13th Annual Trans Health Conference, Philadelphia, PA
February, 2014	Supporting LGBT Families in the NIICU ***Human Rights Campaign Endorsed Training* NIICU Medical Professional Day of Learning The Children's Hospital of Philadelphia, Philadelphia, PA
June, 2013	Contemporary Counseling with Transgender Children, Youth & Families 12th Annual Philadelphia Trans-Health Conference, Philadelphia, PA
April, 2013	Supporting Youth & Young Adults who are Living with HIV Marriage & Family Therapy Program Jefferson University, Philadelphia, PA
March, 2013	LGBT Child & Youth Update: Coming out, therapy needs & family support Marriage & Family Therapy Program Jefferson University, Philadelphia, PA
November, 2012	Creating the Ideal Patient Experience: Serving our Lesbian, Gay, Bisexual and/or Transgender Patients & Families Pride at CHOP Staff Training Seminar Series The Children's Hospital of Philadelphia
November, 2012	The Internet as a Factor in Gender Identity Development for Transgender and Gender Variant Adolescents Society for the Scientific Study of Sexuality Annual National Conference, Tampa, Florida
September, 2012	Building on Classroom Inclusion: Adding a Layer on Gender School-wide Training Greene Street Friends School, Philadelphia, Pennsylvania

EXHIBIT 2

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER; BRIANNA BOE, individually and on behalf of her minor son, MICHAEL BOE; JAMES ZOE, individually and on behalf of his minor son, ZACHARY ZOE; MEGAN POE, individually and on behalf of her minor daughter, ALLISON POE; KATHY NOE, individually and on behalf of her minor son, CHRISTOPHER NOE; JANE MOE, Ph.D.; and RACHEL KOE, M.D.

Plaintiffs,

v.

KAY IVEY, in her official capacity as Governor of the State of Alabama; STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama; DARYL D. BAILEY, in his official capacity as District Attorney for Montgomery County; C. WILSON BAYLOCK, in his official capacity as District Attorney for Cullman County; JESSICA VENTIERE, in her official capacity as District Attorney for Lee County; TOM ANDERSON, in his official capacity as District Attorney for the 12th Judicial Circuit; and DANNY CARR, in his official capacity as District Attorney for Jefferson County.

Defendants.

Civil Action No. 2:22-cv-184-LCB

DECLARATION OF MORISSA J. LADINSKY, MD, FAAP, IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER & PRELIMINARY INJUNCTION

I, Morissa J. Ladinsky, declare as follows:

1. I am an Associate Professor of Pediatrics at the University of Alabama at Birmingham ("UAB") School of Medicine.

2. I am a practicing physician and a member of the medical staff at the Children's Hospital of Alabama and UAB Hospital, both in Birmingham. I am co-lead of the multi-disciplinary gender clinic at UAB Hospital.

3. I obtained a bachelor's degree (magna cum laude) in Human Biology from Brown University in 1985. I obtained my medical degree (with honors) from Baylor University in 1990.

4. I was certified by the American Board of Pediatrics in 1993. I am licensed to practice medicine in Alabama. I have past licensure in Ohio, Maryland, and Texas when I previously practiced and resided in these states.

5. For the last 31 years, I have dedicated my practice to the medical care of young people. Throughout my career, my patients included transgender young people. Presently, those transgender patients live in Alabama, Mississippi, Florida, and Georgia.

6. Since starting at the gender clinic at UAB, I have treated approximately 250 transgender young people for gender dysphoria.

7. The treatment of gender dysphoria is well-established in the medical profession. This is not a pioneering or experimental area of medicine. There are comprehensive standards of care governing the treatment of gender dysphoria that were developed by the World Professional Association for Transgender Health (WPATH), founded in 1979, and Endocrine Society, in collaboration with the Pediatric Endocrine Society. These guidelines are recognized as the prevailing standard of care by the major associations of medical professionals, including the American Medical Association, American Academy of Pediatrics, and the Society for Adolescent Health and Medicine, to name a few. The current version of the WPATH standards of care have been in place for more than a decade.

8. The treatment of gender dysphoria is also part of medical school curricula across the country and world. In fact, this subject is taught as part of the endocrine module to all students at the UAB School of Medicine. The broader topic of transgender medicine is also found on every state board medical exam, including in Alabama.

9. Incorporated within the standards of care is a process each patient must follow before beginning any treatment for gender dysphoria. And, as with any treatment, we also follow a protocol for obtaining informed consent as part of that process. Standard protocol requires that medical treatment for gender dysphoria is

not prescribed until a patient meets the rigorous requirements outlined in the standards of care and consistent with an informed-consent process.

10. The informed consent procedures used by the gender clinic at UAB are very comprehensive. Patients at the clinic begin that process with their primary care provider and often community based mental health provider before they even have an initial appointment with a doctor like me. The patient's mental health provider thoroughly assesses the patient's mental health, maturity, presence and acuity of dysphoria and if indicated, ultimate readiness to undergo medical treatment for gender dysphoria. Using those assessments as our baseline, our multidisciplinary team begins its evaluation. We meet with the patient and their parents/legal guardians, review the risks, benefits, and alternatives of treatment, as medical and mental health providers do for all treatments. After that initial meeting, we meet with our patients at regular intervals for follow up, allowing us to monitor the patient's gender dysphoria as well as their overall physical and mental health over time. The team also provides families with materials to review and community-based supports and resources to connect with in the time between appointments.

11. Most of our patients are in the care of the gender clinic for one to three years before initiating medical treatment for gender dysphoria, depending on when they first come to the clinic and their individual healthcare needs. Even after that extended observation and assessment period, we will not prescribe any treatment

unless the full multidisciplinary team agrees that treatment is appropriate, and the patient and the patient's parents fully understand, have the capacity to consent, and sign the informed-consent forms. This process is intentionally set up to ensure all involved are making an informed, measured decision, from the healthcare providers to the patients and their parents.

12. Throughout this evaluation information-sharing process, patients are encouraged to avail themselves of the various services offered as part of our multidisciplinary clinic, including pastoral care. The purpose of these services is to get a full picture of a patient's health, wellbeing, household support, and functioning. Each of those data points help determine whether a potential treatment option may be appropriate for any given patient.

13. Once a patient begins medical treatment, their progress is monitored at regular intervals, typically every six months, to assess the efficacy of the prescribed treatment through a physical examination or laboratory tests. This ongoing monitoring also ensures ongoing evaluation of a patient's mental health and the chance to address any questions the patient or their parents may have.

14. I understand that Governor Ivey signed the Vulnerable Child Compassion and Protection Act (the "Act"). My understanding is that the Act expressly prohibits physicians, and others, from doing or saying anything that could cause a transgender young person, under age 19, in Alabama to undergo medical

treatment for gender dysphoria. I further understand that violating the Act exposes Alabama healthcare providers and others to criminal prosecution, which could result in a prison sentence or substantial fine.

15. Puberty-blocking medication and hormone-replacement therapy have greatly improved the physical and mental health and wellbeing of my patients. Denying my patients access to these well-established medical treatments will cause the mental health of many of my patients to regress, including increasing their suicidality and likelihood of attempting suicide. To cease ongoing care, without a medical basis, would violate my professional, ethical, and legal obligations by forcing me to harm my patient.

16. In the days since the Act was signed into law, I have met with numerous patients who are experiencing significant psychological distress due to the prospect of the Act going into effect. One teenage patient was visibly trembling in fear. Parents are regularly calling the clinic in tears. The uncertainty weighs heavily on the minds of my patients and their parents. And, for some, their worst fears have already started to materialize: several of my patients have reported to me that their pharmacies are refusing to fill prescriptions relating to the treatment of their gender dysphoria, including for menstrual suppression medications which are supposedly not criminalized by the Act.

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

Executed this 20 th day of April , 2022.

Morissa J. Ladinsky, MD, FAAP

EXHIBIT 3

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER; BRIANNA BOE, individually and on behalf of her minor son, MICHAEL BOE; JAMES ZOE, individually and on behalf of his minor son, ZACHARY ZOE; MEGAN POE, individually and on behalf of her minor daughter, ALLISON POE; KATHY NOE, individually and on behalf of her minor son, CHRISTOPHER NOE; JANE MOE, Ph.D.; and RACHEL KOE, M.D.

Plaintiffs,

v.

KAY IVEY, in her official capacity as Governor of the State of Alabama; STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama; DARYL D. BAILEY, in his official capacity as District Attorney for Montgomery County; C. WILSON BAYLOCK, in his official capacity as District Attorney for Cullman County; JESSICA VENTIERE, in her official capacity as District Attorney for Lee County; TOM ANDERSON, in his official capacity as District Attorney for the 12th Judicial Circuit; and DANNY CARR, in his official capacity as District Attorney for Jefferson County.

Defendants.

Civil Action No.
2:22-cv-184-LCB

DECLARATION OF STEPHEN ROSENTHAL, MD, IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER & PRELIMINARY INJUNCTION

I, Stephen M. Rosenthal, M.D., declare as follows:

1. I submit this expert declaration based upon my personal knowledge.

2. If called to testify in this matter, I would testify truthfully based on my expert opinion.

Qualifications and Experience

3. I am a pediatric endocrinologist and have been practicing medicine for over forty years. I received my medical degree from Columbia University, College of Physicians & Surgeons, in 1976, and completed a residency in Pediatrics there. I also completed a fellowship in Pediatric Endocrinology at the University of California, San Francisco ("UCSF").

4. In 2012, I co-founded the Child & Adolescent Gender Center ("CAGC") at UCSF. I am the Medical Director at the Center, as well as a Professor of Clinical Pediatrics at UCSF. A true and correct copy of my Curriculum Vitae is attached hereto as **Exhibit A**.

5. The Child and Adolescent Gender Center (CAGC) is a multidisciplinary program that provides comprehensive medical and mental health care, as well as education and advocacy services for transgender youth and adolescents. Since 2012, the CAGC has seen close to 2,000 transgender young people with gender dysphoria, with an average of 15-20 new patients per month, ranging in age from 3 to 25 years old. As Medical Director of the CAGC, I oversee

the medical portion of the multidisciplinary program, which currently includes two other physicians, a doctor of nursing practice, one psychologist, a clinical social worker, nursing, and administrative staff.

6. As of the date of this declaration, I have published 27 scientific research papers in leading peer-reviewed medical journals and authored seven chapters in authoritative textbooks on the topic of medical treatment for gender dysphoria in children and adolescents. Those publications include "Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist's View," published in Nature Reviews Endocrinology[1] on August 10, 2021, "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," a guide detailing the standard of medical care for gender dysphoria, and a chapter in the forthcoming standards of care being developed by WPATH. A listing of my publications is included in my Curriculum Vitae in **Exhibit A**.

7. I am also actively serving as a Principal Investigator or Co-Investigator on numerous research projects on the physical and mental health of transgender young people, including a national multi-site study on medical care for transgender young people funded by the NIH.

[1] Nature Reviews Endocrinology received an impact factor of 43.33 for the 2021-2022 publication year.

8. I am a member and recent past president (2016-2017) of the Pediatric Endocrine Society and, as of March, 2021, have just completed a three-year term as a member of the Board of Directors for the Endocrine Society, and one-year term as Endocrine Society Vice President, Clinical Scientist Position. I am also an elected member of the Board of Directors of the World Professional Association for Transgender Health ("WPATH"), an international multidisciplinary professional association founded in 1979 to promote evidence-based care, education, research, advocacy, public policy and respect in transgender health. A complete list of my professional associations is included in my Curriculum Vitae in **Exhibit A**.

9. In addition to my work with transgender children and adolescents, I have treated children and adolescents with differences of sex development ("DSD"), commonly referred to as intersex conditions, as well as with a variety of other endocrine conditions, including growth disorders, pubertal disorders, and diabetes. I previously served as Program Director for Pediatric Endocrinology, Director of the Endocrine Clinics, and Co-Director of the Disorders of Sex Development Clinic, a multi-disciplinary program involving pediatric endocrinology, pediatric urology, psychiatry, and social work at UCSF Benioff Children's Hospital.

10. My opinions contained in this declaration are based on: (i) my clinical experience as a pediatric endocrinologist treating transgender patients, including adolescents and young adults; (ii) my knowledge of the peer-reviewed research,

including my own, regarding the treatment of gender dysphoria, which reflects the clinical advancements in the field of transgender health; and (iii) my review of the expert declaration of Linda A. Hawkins, Ph.D., M.S.Ed., LPC ("Dr. Hawkins Decl.") submitted in support of the motions. I generally rely on these types of materials when I provide expert testimony, and they include the documents specifically cited as supportive examples in particular sections of this declaration. The materials I have relied on in preparing this declaration are the same type of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

11. I was provided with and reviewed the following case-specific materials: the Dr. Hawkins Decl.

12. In the past four years, I have not provided expert testimony.

13. I am being compensated at an hourly rate for the actual time that I devote to this case, at the rate of $350 per hour for any review of records, preparation of reports or declarations. I will be compensated with a day rate (6 hours) of $2,100 for deposition and trial testimony. My compensation does not depend on the outcome of this litigation, the opinions that I express, or the testimony that I provide.

Scientific and Medical Understanding of Sex

14. By the beginning of the twentieth century, scientific research had established that external genitalia alone are not always an accurate indicator of a person's sex. Instead, a person's sex is comprised of several components, including,

among others, internal reproductive organs, external genitalia, chromosomes, hormones, gender identity, and secondary-sex characteristics. Diversity and incongruence in these components of a person's sex are a naturally occurring source of human biological diversity.

15. Scientific research and medical literature across disciplines demonstrate each component of sex has strong biological ties, including gender identity. For example, there are numerous studies detailing similarities in the brain structure and function of transgender and nontransgender people with the same gender identity. In one such study, the volume of the bed nucleus of the stria terminalis (a collection of cells in the central brain) in transgender women was equivalent to the volume found in nontransgender women. There are also studies highlighting the genetic components of gender identity. A study of identical twins found that if one twin was transgender that the other twin was far more likely to be transgender, as compared to the general population.

16. The above studies are representative examples of the growing body of scientific research and medical literature in this area of study. There is also ongoing research on the effects of the hormonal milieu in utero, and genetic sources for gender identity, among others.

17. Although the specific determinants of gender identity remain unknown, treatment to bring a person's physical characteristics into alignment with their

gender identity is widely accepted as the standard in medical practice.

Determination of an Individual's Sex

18. At birth, newborns are assigned a sex, either male or female, typically based solely on the appearance of their external genitalia. For most people, that assignment turns out to be accurate and their assigned sex matches that person's gender identity. However, for transgender people, their assigned sex does not align with their gender identity. This lack of alignment can create significant distress for transgender individuals.

19. When there is a divergence between these factors, medical science and the well-established standards of care recognize that treating a person consistent with their gender identity—and prescribing medical treatment to align their body with their gender identity—is essential to that person's health and wellbeing.

20. Gender identity is a person's inner sense of belonging to a particular gender, such as male or female. It is a deeply felt and core component of human identity. Everyone has a gender identity. Children usually become aware of their gender identity early in life.

21. A person's gender identity is innate, cannot be voluntarily changed, and is not undermined by the existence of other sex-related characteristics that do not align with it.

22. Any attempts to "cure" transgender individuals by forcing their gender

identity into alignment with their assigned sex are harmful, dangerous, and ineffective. Those practices have been denounced as unethical by all major professional associations of medical and mental health professionals, such as WPATH, the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, and the American Psychological Association.

23. For more than four decades, the goal of medical treatment for transgender patients has been to alleviate their distress by bringing their lives into closer alignment with their gender identity. The specific treatments prescribed are based on individualized assessment conducted by medical providers in consultation with the patient's treating mental health provider. As discussed in more detail in the following section, and in the declaration of Dr. Hawkins, research and clinical experience have consistently shown those treatments to be safe, effective, and critical to the health and well-being of transgender patients.

Standards of Care for the Treatment of Gender Dysphoria

24. Due to the incongruence between their assigned sex and gender identity, transgender people experience varying degrees of "gender dysphoria," a serious condition listed in both the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders ("DSM-5") and the World Health Organization's International Classification of Diseases ("ICD-10"), and has been

recognized as such for decades. It is a condition that affects a small percentage of youth and adults.

25. Gender dysphoria is the diagnostic term for the clinically significant distress resulting from the incongruence between a person's gender identity and the sex they are assigned 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.

26. Gender dysphoria is highly treatable and can be effectively managed. If left untreated, however, it can result in severe anxiety and depression, self-harm, and suicidality. 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.

27. The prevailing standards of care for the treatment of gender dysphoria are developed by WPATH, which has been recognized as the standard-setting organization for the treatment of gender dysphoria for more than forty years.

28. The Endocrine Society is a 100-year-old global membership organization representing professionals in the field of adult and pediatric endocrinology. In 2017, the Endocrine Society published its second clinical practice

guidelines on treatment recommendations for the medical management of gender dysphoria, in collaboration with Pediatric Endocrine Society, the European Societies for Endocrinology and Pediatric Endocrinology, and WPATH, among others. Hembree WC, Rosenthal SM, et al. Endocrine Treatment of Gender Dysphoria/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab* 2017; 102: 3869–3903.

29. Together, the SOC and the Endocrine Society's clinical practice guidelines constitute the prevailing standards guiding the healthcare and treatment of gender dysphoria. The process for writing those standard-setting documents followed well-established methods for developing standards of care, beginning with the convening a core group of experts in the relevant field(s) who are tasked with conducting a comprehensive literature review and preparing a draft document. That draft is then circulated to a larger cross-section of practitioners in the relevant field(s) for review and comment, much like the peer-review process for journals. Those edits and comments are incorporated and compiled into a final document that is reviewed and ratified in a manner consistent with the organization's bylaws. As a result, the SOC and the Endocrine Society's clinical practice guidelines reflect the consensus of experts in the field of transgender medicine, based on the best available science and clinical experience.

30. The major professional associations of medical and mental health providers in the United States, including the American Medical Association, American Academy of Pediatrics, American Psychiatric Association, American Psychological Association, and Pediatric Endocrine Society, treat those documents as the prevailing standards guiding the healthcare and treatment of gender dysphoria.

31. Those documents help ensure that healthcare providers, especially those unfamiliar with transgender medicine, know which treatments are safe and effective for the treatment of gender dysphoria, and are able to deliver that necessary medical care to maximize their patients' overall health and wellbeing.

Transition and Medical Treatments for Gender Dysphoria

32. Undergoing treatment to alleviate gender dysphoria is commonly referred to as a transition. The transition process typically includes one or more of the following three components: (i) social transition, including adopting a new name, pronouns, appearance, and clothing, and correcting identity documents; (ii) medical transition, including puberty-delaying medication and hormone-replacement therapy; and (iii) surgical transition, including surgeries to alter the appearance and functioning of primary- and secondary-sex characteristics.

33. The steps that make up a person's transition will depend on that individual's medical and mental health needs, as well as the person's stage of pubertal development.

34. Dr. Hawkins provides an extensive discussion of social transition in her expert declaration. (Dr. Hawkins Decl. at ¶¶ 26–31.) My declaration will discuss the medications and surgical care used to treat gender dysphoria.

35. There are no drug interventions for gender dysphoria until after the onset of puberty. Medical providers evaluate a patient's level of pubertal development through a physical examination and testing the hormone levels in the patient's blood. Once a provider has determined that a transgender patient has begun puberty, the patient may be prescribed puberty-blocking medications.

36. Those medications work by temporarily pausing endogenous puberty and, therefore, limiting the influence of a person's endogenous sex hormones on their body. For example, a transgender girl (someone designated male at birth with a female gender identity) will experience no progression of physical changes caused by testosterone, including facial and body hair, an Adam's apple, a deepened voice, or masculinized facial structures. And in a transgender boy (someone designated female at birth with a male gender identity), those medications would prevent progression of breast development, menstruation, and widening of the hips. This prevents a transgender adolescent from experiencing the severe psychological distress of developing permanent, unwanted physical characteristics that do not align with the adolescent's gender identity.

37. Temporarily halting a transgender adolescent's pubertal development can also obviate the need for future surgical treatments to address any ongoing gender dysphoria. Avoiding the scarring associated with surgery—and the added stresses of surgery itself—further improve a transgender person's overall health and wellbeing.

38. A transgender adolescent will remain on those puberty-blocking medications until their providers determine, in consultation with the patient, the patient's family, and consistent with the prevailing standards of care, whether additional medical treatment is necessary to treat their gender dysphoria. If the decision is to stop taking puberty blockers, the patient's endogenous puberty will resume.

39. For many transgender youth, it is medically necessary for them to begin hormone-replacement therapy with either testosterone or estrogen. That treatment induces the physical changes of the puberty associated with the patient's gender identity. The result of this treatment is that a transgender boy has the same typical levels of circulating testosterone as his nontransgender male peers. Similarly, a transgender girl will have the same typical levels of circulating estrogen as her nontransgender female peers. Those hormones cause transgender adolescents to undergo the same significant and permanent sex-specific physical changes as their nontransgender peers. For example, a transgender boy will develop a lower voice as

well as facial and body hair, while a transgender girl will experience breast growth, female fat distribution, and softer skin.

40. If a transgender youth who is on puberty blockers and hormone-replacement therapy ceases these medications, the production of endogenous hormones and puberty consistent with the individual's birth sex will resume.

41. Puberty-delaying medication and hormone-replacement therapy—both individually and in combination—also significantly improve a transgender young person's mental health because those medications ensure their physical appearance more closely aligns with their gender identity. This also decreases the likelihood that a transgender young person will be incorrectly identified with their birth sex, further alleviating their gender dysphoria and bolstering the effectiveness of their social transition.

42. The puberty-delaying medications that are used for treating transgender children are the same medications that have been used for decades and are continued to be used to treat a condition in children often referred to as "precocious puberty," a condition that causes a child's body to begin pubertal development too early. In other words, the hormone therapy used to treat transgender adolescents is often used to treat non-transgender adolescents for other medical reasons.

43. Social transition and hormone therapy are often sufficient to treat gender dysphoria for many transgender people.

44. Based on my clinical experience, there are transgender young people for whom getting on puberty blockers and hormones before the age of majority will reduce the likelihood of their needing surgical intervention later in life relating to gender dysphoria.

45. Further, recent studies have observed findings that gender-affirming hormone therapy usage is significantly related to lower rates of depression and suicidality among transgender youth. Green AE et al. Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. *J Adolescent Health* 1-7 (2021); Turban JL et al. Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. PLoS ONE 17(1) 2021; https://doi.org/10.1371/journal. pone.0261039.

46. For transgender people who require surgery to treat their gender dysphoria, the SOC do not recommend surgical treatment until the age of majority, except for male chest reconstruction surgery. Like any other treatment, the medical necessity of surgical procedures to treat gender dysphoria is based on an individualized assessment of the patient's needs.

Assessing Medical Necessity of Medical Treatment for Gender Dysphoria

47. As with the initial diagnosis of gender dysphoria, determining whether a particular treatment is medically necessary for a transgender patient follows a

thorough, well-established process that requires healthcare providers to exercise professional judgment. Contrary to what some believe, prescriptions for puberty-blocking medication and hormone-replacement or referrals for surgery are not made on a whim. Every step of a transgender patient's treatment and care is planned out in consultation with the patient's care team, which includes both medical and mental health providers.

48. Prior to considering starting a course of puberty-blockers or hormone-replacement therapy, a transgender patient undergoes an extensive assessment by a mental health provider. The purpose of that assessment is three-fold: (1) obtaining a complete picture of the patient's mental health, including whether the patient has gender dysphoria; (2) determine the patient's psychological readiness to begin the contemplated treatment; and (3) provide the patient and their family the information they need to make an informed decision about whether to proceed with the treatment. If, after that assessment, the mental health provider determines that the patient should be considered for the contemplated treatment, that professional opinion is documented in a letter to the patient's medical provider.

49. The medical provider then conducts their own separate assessment of the patient, including a physical examination and any necessary laboratory testing. In addition to determining the medical necessity of the contemplated treatment and a patient's medical readiness for that treatment, the medical provider will also

discuss the risks, benefits, and alternatives for the contemplated treatment. Medical providers also discuss with parents that the medications are being prescribed for an off-label use, which is particularly common for medications being used in pediatric patients. That discussion occurs with the patient and their family to ensure that everyone involved in the decision-making process has the information they need to make an informed decision.

50. Once the medical provider has finished addressing any questions or concerns raised by the patient and family, the parents/legal guardians and the patient are provided with a detailed informed consent/assent form that outlines in writing the information the medical provider reviewed with them. The patient and family are encouraged to carefully review that paperwork and sign if they choose to consent/assent to treatment.

51. It is only at the end of that intensive assessment and informed-consent process that a patient is prescribed a particular medical treatment for gender dysphoria.

Medical Treatment for Gender Dysphoria is Evidence-Based Medicine

52. Research and clinical experience repeatedly reaffirm that transition significantly improves the mental and physical health of transgender young people.

53. This is true of each stage of a transgender young person's transition. Transgender young people who underwent a social transition in childhood

demonstrated better mental health profiles than prior studies of gender nonconforming children. *See* Lily Durwood, et al., *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*, 56 J. Am. Acad. of Child & Adol. Psychiatry 116 (2017); Kristina Olson, et al., *Mental Health of Transgender Children who are Supported in Their Identities*, 137 Pediatrics 1 (2016). This same outcome has also been seen in a longitudinal study of transgender young people who underwent each of the three stages of transition outlined above. Annelou L.C. de Vries, et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014). In a study specifically about male chest reconstruction surgery, post-operative transgender young people demonstrated significant psychological and functional improvements, from a greater willingness to plan for their future and to engage activities of daily living (e.g., bathing, buying clothing). Johanna Olson-Kennedy, et al., *Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults Comparisons of Nonsurgical and Postsurgical Cohorts*, 172 JAMA Pediatrics 431, 434 (2018)

54. Transition also can—and often does—alleviate co-occurring mental health issues a transgender young person experienced prior to transition. Following transition, transgender young people typically see significant improvements in functioning and quality of life. Treating their gender dysphoria also increases a

transgender young person's capacity to develop and maintain better coping strategies to manage any co-occurring conditions.

55. Conversely, delaying or denying transgender young people safe and effective treatment for gender dysphoria—as contemplated by the wait-and-see approach—can have severe consequences on their physical and mental health. Without those medically necessary treatments, transgender young people are likely to develop serious co-occurring mental health conditions (*i.e.* anxiety, depression, suicidality) that will interfere with their ability to learn and impede their psychosocial development.

Conclusion

56. Alabama's law criminalizing the provision of medical treatment for gender dysphoria is contrary to well-established standards of care, peer-reviewed medical literature, and clinical experience. Medical care for transgender young people in Alabama would be guided by fear of criminal penalty, forcing medical providers to abandon their professional and ethical obligations to follow the prevailing standards of care when treating patients with gender dysphoria.

57. Contrary to its stated purpose, this bill will endanger the health and wellbeing of transgender young people experiencing gender dysphoria by creating significant barriers to their receiving medically necessary care. The lack of access to

that time-sensitive care will have lifelong implications for their quality of life and their ability to effectively treat their gender dysphoria.

This declaration was executed this 19th day of April, 2022.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

By: Stephen M. Rosenthal
Stephen M. Rosenthal, M.D.

EXHIBIT A

Prepared: May 26, 2020

University of California, San Francisco

CURRICULUM VITAE

Name: Stephen M Rosenthal, MD

Position: Recalled Faculty
Pediatrics
School of Medicine

Address: Mission Hall, Box 0434
550 16th Street, 4th Floor
University of California, San Francisco
San Francisco, CA 94143
Voice: 415-476-2266
Fax: 415-476-5356
Email: Stephen.Rosenthal@ucsf.edu

EDUCATION

1968 - 1972	Yale University	BA	Psychology
1972 - 1976	Columbia University, Colege of Physicians & Surgeons	MD	
1976 - 1977	Columbia University, Presbyterian Hospital	Intern	Pediatrics
1977 - 1979	Columbia University, Presbyterian Hospital	Resident	Pediatrics
1979 - 1982	University of California, San Francisco	Fellow	Pediatric Endocrinology

LICENSES, CERTIFICATION

1980	Medical License, California, #G42045
1982	American Board of Pediatrics
1983	American Board of Pediatric Endocrinology

PRINCIPAL POSITIONS HELD

1982 - 1983	University of California, San Francisco	Instructor	Pediatrics
1983 - 1992	University of California, San Francisco	Assistant Professor in Residence	Pediatrics
1992 - 1998	University of California, San Francisco	Associate Professor in Residence	Pediatrics

1998 - 2012	University of California, San Francisco	Professor in Residence	Pediatrics
2012 - present	University of California, San Francisco	Professor of Clinical Pediatrics	Pediatrics

OTHER POSITIONS HELD CONCURRENTLY

2006 - 2015	University of California, San Francisco	Director, Pediatric Endocrine Outpatient Services	Pediatrics
2008 - 2011	University of California, San Francisco	Associate Program Director, Pediatric Endocrinology	Pediatrics
2008 - 2018	University of California, San Francisco	Pediatric Endocrine Director, Disorders of Sex Development (DSD) Clinic	Pediatrics
2011 - present	University of California, San Francisco	Medical Director, Child & Adolescent Gender Center	Pediatrics
2012 - 2015	University of California, San Francisco	Program Director, Pediatric Endocrinology	Pediatrics

HONORS AND AWARDS

2011	Nominated for the Chancellor's Award for Gay, Lesbian, Bisexual, and/or Transgender Leadership for a faculty member	University of California, San Francisco
2012	Nominated for the Chancellor's Award for Gay, Lesbian, Bisexual, and/or Transgender Leadership for a faculty member	University of California, San Francisco
2012	Family Advisory Council Caring Tree Award	UCSF Benioff Children's Hospital
2013	Chancellor's Award for Gay, Lesbian, Bisexual, and Transgender (GLBT) Leadership in the faculty category	University of California, San Francisco

2014	Haile T. Debas Academy of Medical Educators Excellence in Teaching Award	University of California, San Francisco
2018	Harry Benjamin Lectureship, World Professional Association for Transgender Health, for significant contributions to the field of transgender health through research, healthcare provision and medical education	World Professional Association for Transgender Health

KEYWORDS/AREAS OF INTEREST

Biology of gender, transgender, Disorders of Sex Development (DSD), Insulin-like Growth Factors (IGFs), neuroblastoma, water balance disorders, Type 1 Diabetes, medical education, fellowship training.

CLINICAL ACTIVITIES

CLINICAL ACTIVITIES SUMMARY

I currently serve as Medical Director, Child and Adolescent Gender Center, a UCSF/ Community partnership designed to provide multidisciplinary services for pediatric and adolescent gender nonconforming/ transgender patients. I have served as Pediatric Endocrine Director, Disorders of Sex Development (DSD) monthly clinic, a multi-disciplinary program involving Pediatric Endocrinology, Pediatric Urology, Psychiatry, and Social Work. I currently Attend in the out-Patient clinics: Currently, 2 clinics/ week.

PROFESSIONAL ACTIVITIES

MEMBERSHIPS

1983 - present	The Endocrine Society
1983 - present	The Pediatric Endocrine Society (formerly known as the Lawson Wilkins Pediatric Endocrine Society)
1983 - 2000	Western Society for Pediatric Research
1986 - present	The Society for Pediatric Research
2011 - present	World Professional Association for Transgender Health (WPATH)

SERVICE TO PROFESSIONAL ORGANIZATIONS

1990 - 1993	Pediatric Endocrine Society	Member, Organizing Committee for the Combined Lawson Wilkins Pediatric Endocrine Society and the European Endocrine Society IV International Meeting

1999 - 1999	Society for Insulin-like Growth Factor Research	Member, Scientific Planning Committee, 5th International Symposium on Insulin-Like Growth Factors, Brighton, UK
2000 - 2005	Pediatric Endocrine Society	Member, Drug and Therapeutics Committee
2002 - 2005	The Endocrine Society	Member, Special Programs Committee
2003 - 2004	Pediatric Endocrine Society	Chair, Drug and Therapeutics Committee
2005 - 2008	The Endocrine Society	Member, Science and Educational Programs Core Committee
2006 - 2006	Eli Lilly Co.	Member, National Growth Hormone Clinical Physicians Advisory Panel
2007 - 2013	Pediatric Endocrine Society	Member, Ethics Committee
2007 - 2007	Pediatric Endocrine Society, Growth Hormone Research Society, and European Society of Pediatric Endocrinology	Member, Consensus Workshop Committee on Diagnosis and Management of Idiopathic Short Stature
2008 - present	The Endocrine Society	Abstract Reviewer/Grader
2008 - 2011	The Endocrine Society	Member, Annual Meeting Steering Committee
2009 - 2009	Pediatric Endocrine Society and European Society of Pediatric Endocrinology	Abstract Reviewer/Grader

2009 - 2011	The Endocrine Society	Team Leader, Annual Meeting Steering Committee
2010 - 2013	Pediatric Endocrine Society	Elected to Board of Directors
2012 - 2012	The Endocrine Society	ENDO 2012 Presidential Poster Competition Judge
2012 - 2015	Pfizer, Inc.	Review Committee: ASPIRE Young Investigator Awards in Endocrine Research
2012 - 2015	The Endocrine Society	Member, Clinical Endocrine Education Committee
2012 - present	Pediatric Endocrine Society	Member, Honors Committee
2013 - 2017	Pediatric Endocrine Society	Member, Maintenance of Certification Committee
2014 - 2017	Endocrine Society and Pediatric Endocrine Society	Official representative of Pediatric Endocrine Society to Endocrine Society's Clinical Practice Guidelines Revision Task Force for the Care of Transgender Individuals
2015 - 2016	Pediatric Endocrine Society	President-elect
2016 - 2017	Pediatric Endocrine Society	President
2017 - 2018	Pediatric Endocrine Society	Immediate Past President
2017 - 2018	Pediatric Endocrine Society	Chair, Honors and Awards Committee
2018 - 2019	Endocrine Society	Vice President, Clinical Scientist Position

2019 - present	Endocrine Society	Member, Board of Directors

SERVICE TO PROFESSIONAL PUBLICATIONS

1986 - present	Reviewer, Journal of Clinical Endocrinology and Metabolism
1987 - present	Reviewer, Endocrinology
1991 - 1993	Reviewer, DNA and Cell Biology
1991 - 2000	Reviewer, Life Sciences
1992 - present	Reviewer, Diabetes
1993 - 2008	Reviewer, Cancer Research
1994 - present	Reviewer, Molecular Endocrinology
1995 - present	Reviewer Journal of Cell Physiology
1996 - 2000	Reviewer, Journal of Cell Biology
1998 - 2008	Reviewer, Journal of Biological Chemistry
2006 - present	Reviewer, Journal of Pediatric Endocrinology and Metabolism
2010 - present	Reviewer, International Journal of Pediatric Endocrinology
2015 - 2018	Associate Editor, Transgender health
2015 - present	Editorial Board Member, International Journal of Transgenderism

INVITED PRESENTATIONS - INTERNATIONAL

1984	7th International Congress of Endocrinology, Quebec, Canada	Lecture
1985	Symposium "Therapeutic Agents Produced by Genetic Engineering: Quo Vadis? - The Example of Growth Hormone and Its Releasing Factor", Toulouse, France,	Invited lectures (2)
1985	28 emes Journees Internationales Henri-Pierre Klotz D'Endocrinologie Clinique, Paris, France	Invited lecture
1986	1st International Congress of Neuroendocrinology, San Francisco	Invited lecture
1988	GRF Symposium, Sanofi Group, Paris, France	Invited lecture
1990	Serono Symposium "Major Advances in Human Female Reproduction", Rome, Italy	Invited lecture and Session chair
1990	3rd International Symposium on Molecular and Cellular Biology of Insulin and IGFs, Gainesville, FL	Poster
1991	2nd International Symposium on Insulin-Like Growth Factors/Somatomedins, San Francisco,	Posters (2)

1992	9th International Congress of Endocrinology, Nice, France	Poster
1993	4th International Symposium on Insulin, IGFs, and Their Receptors, Marine Biological Laboratory, Woods Hole, MA	Poster
1993	LWPES/ESPE Fourth Joint Meeting, San Francisco, CA	lecture, Poster, & Session chair
1994	The Third International Symposium on Insulin-Like Growth Factors, Sydney, Australia	Invited lecture
1994	AgResearch, Hamilton, New Zealand (lecture title: "Insulin-like Growth factors and Skeletal Muscle Differentiation")	Invited lecture and Visiting Professor
1994	Jacques Ducharme Annual Lectureship, University of Montreal, Canada	Invited lecture
1995	5th International Symposium on Insulin and IGFs, Gainesville, FL	Poster
1996	10th International Congress of Endocrinology, San Francisco, CA	Platform
1997	5th Joint Meeting of the European Society for Pediatric Endocrinology and the Lawson Wilkins Pediatric Endocrine Society, Stockholm, Sweden	Platform
1997	4th International Symposium on Insulin-like Growth Factors, Tokyo, Japan	Platform
1999	5th International Symposium on Insulin-like Growth Factors, Brighton, UK	Platform, Session chair, Member, Scientific Planning Committee
2000	Symposium Medicus Conference on Adolescent Medicine, Ixtapa, Mexico	Invited lectures (3)
2001	6th Joint Meeting of the European Society for Pediatric Endocrinology and the Lawson Wilkins Pediatric Endocrine Society, Montreal, Canada	Platform
2001	William Soler Children’s Hospital, Havana, Cuba	Invited lecture and Visiting Professor
2002	First Joint Symposium GH-IGF 2002, Boston, MA	Platform
2002	2nd Cuban Symposium on Immunology of Diabetes, Havana, Cuba	Invited lecture

2005	Canadian Society of Endocrinology and Metabolism and Canadian Diabetes Association Annual Meeting, Edmonton, Alberta, Canada, (Pediatric Symposium on: Activating Mutations: Genetic Basis and Therapeutic Implications)	Invited lecture
2006	38th International Symposium: GH and Growth Factors in Endocrinology and Metabolism, Granada Spain, [“Hot Topics” session: Lecture title: “Nephrogenic Syndrome of Inappropriate Antidiuresis (NSIAD): A Paradigm for Activating Mutations Causing Endocrine Dysfunction]	Invited lecture
2006	Sanofi-Aventis, Paris, France, (Lecture title: “Potential Use of Selective V2 Vasopressin Receptor Antagonists as Inverse Agonists in the Treatment of Nephrogenic Syndrome of Inappropriate Antidiuresis”)	Invited lecture
2006	Primary Insulin-like Growth Factor-I Deficiency (IGFD) International Advisory Board Meeting, Tercica, Inc., San Francisco, CA,	Invited speaker
2007	1er Simposio Argentino Noditropin Simplex en Endocrinologia Pediatrica, Punta del Este, Uruguay, (Lecture titles: “Primary IGF-I Deficiency”; and “Activating Mutations of the V2 Vasopressin Receptor”)	Invited Plenary Lectures (2)
2007	GeNeSIS Investigators Meeting, Paris, France, (Panel : “Growth Attenuation: Current Concepts and Controversies”)	Invited Panel Member
2007	Idiopathic Short Stature (ISS) Consensus Conference/International Meeting, Santa Monica, CA	Invited participant and Session chair
2008	5th Biennial Scientific Meeting of the Asia Pacific Pediatric Endocrine Society, Seoul, Korea, [Lecture title: “Nephrogenic Syndrome of Inappropriate Antidiuresis (NSIAD): Recent Insights”]	Invited Plenary Lecture
2009	Nordiscience Forum (Novo Nordisk’s International Scientific Meeting), Kyoto, Japan, (Lecture title: “Disorders of Water Balance and the Nephrogenic Syndrome of Inappropriate Antidiuresis”)	Invited Plenary Lecture
2009	Osaka University, Osaka, Japan (Lecture title: “IGFs: Links to Cancer and Longevity”)	Invited Lecture/Visiting Professor
2009	National Center for Child Health and Development, Tokyo, Japan (Lecture title: "Growth as a Barometer of Health")	Invited Lecture

2010	The Society for Pediatric Research/ Lawson Wilkins Pediatric Endocrine Society, Vancouver, Canada, (“Meet-the Professor” title: “Career Development: What’s Next After Fellowship?”)	Invited speaker/ "Meet-the Professor"
2011	9th Winter Symposium, Department of Child Health, Christian Medical College, Vellore, India (Lecture title: “Water & Sodium Balance: Current Concepts & Clinical Implications”)	Invited Plenary Lecture
2011	World Professional Association for Transgender Health (WPATH) Biennial Symposium (International), Atlanta, GA	Invited speaker/ panel presentation
2012	1st St. Luke's International Conference on Pediatrics: Enhancing Pediatric Care with the Experts, Global City, Taguig City (Manila), Philippines (2 Lectures: "Gender Non-Conforming/Transgender Youth: Endocrine Considerations"; "Abnormalities of Puberty"; Case Discussant: "Disorders of Sex Development")	Invited Plenary Lectures
2013	World Professional Association for Transgender Health (WPATH) ICD-11 Consensus Meeting, San Francisco, CA	Invited Participant
2014	World Professional Association for Transgender Health (WPATH) Biennial Symposium, Bangkok, Thailand	Invited Symposium speaker
2014	Chulalongkorn University, Bangkok, Thailand (Lecture title: "Gender Nonconforming Transgender Youth: Endocrine Considerations")	Invited Lecture/Visiting Professor

INVITED PRESENTATIONS - NATIONAL

1983	The Endocrine Society Annual Meeting	Platform
1985	Endocrine Days, Seattle Washington	Invited lecture
1986	The Endocrine Society Annual Meeting	Platform
1987	The Clinical Research Center Program Directors' Biennial Meeting, NIH, Williamsburg, VA	Lecture
1987	Growth Disorders: Diagnostic and Therapeutic Dilemmas, Eli Lilly, Boston, MA	Invited lecture
1989	Society for Pediatric Research Annual Meeting	Poster
1990	Society for Pediatric Research Annual Meeting	Poster
1990	The Endocrine Society Annual Meeting	Poster
1990	American Academy of Pediatrics Postgraduate Course "Recent Advances in Endocrinology", Seattle, WA	Invited lectures (2)

1990	Eli Lilly Symposium "Roundtable Discussion Group on Current Issues in Pediatric Endocrinology", Dallas, TX	Invited lecture and Session chair
1991	NIH Workshop on Biological Consequences of Early Placental Loss, San Juan, Puerto Rico	Invited lecture
1991	The Endocrine Society Annual Meeting	Poster
1992	American Academy of Pediatrics Annual Meeting, San Francisco, CA	Invited lecture
1992	The Endocrine Society Annual Meeting	Poster
1994	The Endocrine Society Annual Meeting	Poster and Session chair
1994	Genentech National Cooperative Growth Study Symposium, Orlando, FL	Session Chair
1995	American Academy of Pediatrics, PREP: The Course, Santa Monica, CA	Invited lectures (2)
1995	The Endocrine Society Annual Meeting	Poster
1995	American Academy of Pediatrics, PREP: The Course, Minneapolis, MN	Invited lectures (2)
1997	The Endocrine Society Annual Meeting	Poster
1998	The Endocrine Society Annual Meeting	Poster
1999	The Endocrine Society Annual Meeting	Poster
2000	The Endocrine Society Annual Meeting	Poster and Session chair
2001	The Endocrine Society Annual Meeting	Poster
2002	The Endocrine Society Annual Meeting	Poster
2004	The Endocrine Society Annual Meeting	Poster
2003	Society for Women’s Health Research: Fourth Annual Conference on Sex and Gene Expression, Winston-Salem, NC	Invited lecture and Session chair
2004	Society for Pediatric Research Annual Meeting	Poster
2005	The Endocrine Society Annual Meeting	Poster
2005	American Academy of Pediatrics, PREP: The Course, Miami, FL	Invited lectures (2)
2005	American Academy of Pediatrics, PREP: The Course, Portland, OR	Invited lectures (2)
2005	GeNeSIS Symposium and Investigators Meeting, Washington, D.C.	Session chair

2006	The Endocrine Society Annual Meeting, Boston, MA (Symposium lecture title: “How We Define IGF-I Deficiency”)	Invited lecture
2006	The Endocrine Society’s Clinical Endocrinology Update Course, San Francisco, CA (Lecture title/ “Meet-the Professor”: “Management of Type 2 Diabetes in Adolescence”)	Invited lecture/ "Meet-the-Professor"
2006	Serono GH Monitor Investigator Meeting, Symposium on Disorders of Water Balance, San Francisco, CA, 2006	Invited Plenary Lecture
2007	The Endocrine Society Annual Meeting	Poster
2008	American Academy of Pediatrics, PREP: The Course, Tempe, AZ, 2008	Invited lectures (2)
2008	The Endocrine Society Annual Meeting	Poster
2008	Society for Pediatric Research Annual Meeting	Session Co-Chair
2008	Lawson Wilkins Pediatric Endocrine Society Annual Meeting	Session Co-Chair
2009	American Academy of Pediatrics, PREP: The Course, Savannah, GA	Invited lectures (2)
2009	The Endocrine Society Annual Meeting, Washington, DC (Lecture title/ “Meet-the-Professor”: “Hyponatremia in Infants & Children”)	Invited speaker/ "Meet-the-Professor"
2009	The Endocrine Society Annual Meeting	Poster
2009	American Academy of Pediatrics, PREP: The Course, Portland, OR	Invited lectures (2)
2009	Disorders of Sex Development (DSD) Research and Quality Improvement Symposium, University of Michigan Initiative on Rare Disease Research, Ann Arbor, MI	Invited participant
2010	The Endocrine Society Annual Meeting, San Diego, CA (Lecture title/ “Meet-the-Professor”: “Hyponatremia in Infants & Children”)	Invited speaker/ "Meet-the-Professor"
2010	American Academy of Pediatrics, NeoPREP, Newport Beach, CA	Invited lectures (2)
2012	45th Annual Advances & Controversies in Clinical Pediatrics, UCSF, San Francisco, CA (Lecture title: "Gender-Variant/Transgender Youth: Endocrine Considerations")	Invited lecture
2012	The Endocrine Society Annual Meeting	Session Co-Chair
2012	American Academy of Pediatrics, PREP: The Course, San Diego, CA	Invited Lecture and Case Presentations

2013	Miami Children's Hospital 16th Annual Pediatric Board Review Course	Invited Lecture and Case Presentations
2013	National Transgender Health Summit (sponsored by UCSF), Oakland, CA (Lecture title/"The Biology of Gender")	Invited Lecture and Panel Presentations
2013	Pediatric Endocrine Society Annual Meeting: Plenary Ethics Debate: "Approach to the Prepubertal Gender Non-Conforming Child: Should Intervention Attempt to Support the Assigned or Affirmed Gender?"	Program Chair and Speaker
2013	American Academy of Pediatrics, PREP: The Course, Portland, OR	Invited Lecture and Case Presentations
2013	The Endocrine Society Annual Meeting	Symposium Chair
2013	American Academy of Pediatrics: "Mind Matters for Pediatric Practitioners", San Francisco, CA (Lecture title: "Gender Nonconforming/ Transgender Youth: Endocrine Considerations")	Invited Lecture
2014	American Academy of Pediatrics, NeoPREP: An Intensive Review and Update of Neonatal/Perinatal Medicine, San Diego, CA (Lecture title: "Neontal Thyroid Disorders")	Invited lecture
2014	UCSF CME: Diabetes Update and Advances in Endocrinology and Metabolism (Lecture title: "Gender Nonconforming/ Transgender Youth: Endocrine Considerations")	Invited Lecture
2014	1st Annual Disorders of Sex Development-Translational Research Network (DSD-TRN)) and Accord Alliance (AAN) Workshop, Phoenix Children's Hospital, Phoenix, AZ	Invited participant
2014	Endocrine Society Annual Meeting	Symposia (2) Chair
2014	UCSF CME: Current Trends in DSD Management	Course Chair and Lecturer

INVITED PRESENTATIONS - REGIONAL AND OTHER INVITED PRESENTATIONS

1983	Pediatric Grand Rounds, John Muir Hospital, Veterans Administration Hospital, San Francisco, Santa Rosa Community Hospital, Fresno Valley Children’s Hospital, University of the Pacific, Mt. Zion Hospital, Oak Knoll Naval Hospital	Invited lectures
1984	Pediatric Grand Rounds, UCSF	Invited lecture
1985	Pediatric Grand Rounds, UCSF	Invited lecture

1985	Western Socity for Pediatric Research Annual Meeting	Platform
1986	Pediatric Grand Rounds, UCSF	Invited lecture
1987	Pediatric Grand Rounds, UCSF	Invited lecture
1989	Visiting Professor, University of Florida, Gainesville, FL	Invited lecture
1989	Visiting Professor, University of Pittsburgh, Pittsburgh, PA	Invited lecture
1989	Pediatric Grand Rounds, UCSF	Invited lecture
1990	Pediatric Grand Rounds, UCSF	Invited lecture
1992	Rocky Mountain Endocrine Society, Salt Lake City, UT	Invited lectures (2)
1993	Western Socity for Pediatric Research Annual Meeting	Session Co-Chair
1993	Organization of Pediatric Endocrinologists of California, Sonoma, CA	Invited lecture
1993	Pediatric Grand Rounds, San Francisco General Hospital	Invited lecture
1994	Organization of Pediatric Endocrinologists of California, Yosemite, CA	Meeting Chair
1995	Pediatric Grand Rounds, San Francisco General Hospital	Invited lecture
1997	Visiting Professor, University of Utah, Salt Lake City, UT	Invited lecture
1998	Visiting Professor, University of Washington, Seattle, WA	Invited lecture
1998	American Academy of Pediatrics Annual Meeting, St. Petersburg, Florida	Invited lecture
1998	Genentech, Inc., South San Francisco, CA	Invited lecture
1998	Pediatric Grand Rounds, Fresno Medical Education Program	Invited lecture
1999	Pediatric Grand Rounds, UCSF	Invited lecture
2000	Natural Cooperative Growth Study (co-sponsored by University of Oregon and Genentech, Inc.), San Francisco, CA	Invited lecture
2000	“Advances and Changing Trends” (Pediatrics), The Lloyd Noland Foundation, Orlando, FL	Invited lectures (2)
2000	Michigan State Medical Society Annual Scientific Meeting, Detroit, MI	Invited Plenary Lecture
2000	Pediatric Grand Rounds, San Francisco General Hospital	Invited lecture

2001	UCSF Diabetes Center (Lecture title: "Insulin-like Growth Factors and Skeletal Muscle Differentiation")	Invited lecture
2002	“Ninth Annual Pediatrics Update”, The Lloyd Noland Foundation, Hilton Head Island, SC	Invited lectures (3)
2003	Symposium Medicus Conference on Adolescent Medicine, Puerto Rico	Invited lectures (3)
2004	Pediatric Grand Rounds, UCSF (Lecture title: “Insulin-like Growth Factors: Not Really Like Insulin”)	Invited lecture
2005	Endocrine Grand Rounds, UCSF (Lecture title: “Nephrogenic Syndrome of Inappropriate Antidiuresis”)	Invited lecture
2005	Symposium Medicus Conference on Pediatrics, Yosemite, CA	Invited lectures (3)
2006	Pediatric Grand Rounds, Childrens Hospital Los Angeles, University of Southern California (Lecture title: “Nephrogenic Syndrome of Inappropriate Antidiuresis")	Invited lecture
2006	UCSF Diabetes Update and Advances in Endocrinology and Metabolism, “Nephrogenic Syndrome of Inappropriate Antidiuresis (NSIAD): A Paradigm for Activating Mutations Causing Endocrine Disease”, San Francisco, CA	Invited lecture
2006	“Childhood Matters” Radio Show, “Diabetes in Childhood: Who’s at Risk?”, KISS-FM, San Francisco, CA	Invited speaker (radio)
2006	Pediatric Grand Rounds, Sutter Medical Center, Santa Rosa, CA (Lecture title: “Growth as a Barometer of Health”)	Invited lecture
2006	Pediatric Grand Rounds, California Pacific Medical Center, San Francisco, CA (Lecture title: “Growth Hormone and IGF-I Treatment for Short Stature: Current Concepts and Controversies”)	Invited lecture
2007	Pediatric Endocrine Grand Rounds, University of California Los Angeles (Lecture title: “Activating V2 Vasopressin Receptor Mutations")	Invited lecture
2007	UCSF Pediatric Diabetes Symposium: “Type 1 Diabetes: Primary and Secondary Prevention”	Invited lecture
2008	Pediatric Grand Rounds, University of Massachusetts, Baystate Children’s Hospital: “Nephrogenic Syndrome of Inappropriate Antidiuresis (NSIAD): A Paradigm for Activating Mutations Causing Endocrine Dysfunction"	Invited lecture

2008	UCSF Pediatric Diabetes Symposium: “Can We Prevent Type 1 Diabetes? : Research Update”	Invited lecture
2008	Juvenile Diabetes Research Foundation, Hawaii Chapter, Honolulu, HI: “Update in Type I Diabetes Research: Honeymoon Prolongation and Primary Prevention"	Invited lecture
2009	Organization of Pediatric Endocrinologists of California, San Francisco, CA, “IGFs: Links to Cancer and Longevity”	Invited lecture
2009	Pediatric Grand Rounds, Marin General Hospital, San Francisco, CA, (Lecture title: “Growth Disorders: Current Concepts and Management”)	Invited lecture
2009	Pediatric Grand Rounds, San Francisco General Hospital (Lecture title: “Gender Identity Disorder in Pre-Adolescents & Adolescents”)	Invited lecture
2009	UCSF School of Medicine, Pediatric Interest Group: “Career Development in Pediatric Endocrinology"	Invited speaker
2010	Pediatric Grand Rounds, UCSF (Lecture title: “Gender Variant/ Transgender Youth: Endocrine Considerations”)	Invited lecture
2010	Children’s Hospital Oakland Research Institute, Oakland, CA, “Gender Variant/ Transgender Youth: Endocrine Considerations”	Invited lecture
2010	Symposium Medicus Conference on Pediatrics (Lecture titles: “Abnormalities of Puberty”, “Update in Type 1 Diabetes”, “Growth as a Barometer of Health”) Kauai, Hawaii	Invited lectures (3)
2010	Gender Spectrum 4th Annual Family Conference (Lecture title: “The Use of Pubertal Blockers in Gender Variant Youth”, Berkeley, CA	Invited lecture
2010	UCSF School of Medicine, Pediatric Interest Group: “Career Development in Pediatric Endocrinology"	Invited speaker
2010	UCSF Pediatric Noon Cnference Series (Lecture title: "Neonatal Thyroid Disorders")	Invited lecture
2011	Pediatric Grand Rounds, Riley Hospital, University of Indiana, Indianapolis, IN, (Lecture title: "Gender Variant/Transgender Youth: Endocrine Considerations")	Invited lecture
2011	Pediatric Grand Rounds, Lucile Packard Children's Hospital, Stanford University, Stanford, CA, (Lecture title: "Gender Variant/Transgender Youth: Endocrine Considerations")	Invited lecture

2011	UCSF Pediatric Noon Cnference Series (Lecture title: "Abnormalities of Puberty")	Invited lecture
2011	Gender Spectrum 5th Annual Family Conference (Lecture title: “The Biology of Gender”), Berkeley, CA	Invited lecture
2011	Gender Spectrum Professional's Workshop, Berkeley, CA (“The Use of Pubertal Blockers in Gender Variant Youth”)	Invited speaker, panel presentation
2011	"Mind-the-GAP" Mental Health Professionals Workshop, Oakland, CA (Lecture title: "The Use of Pubertal Blockers in Gender Variant Youth”)	Invited lecture
2011	8th Annual Great Plains Pediatric Endocrine Symposium (Lecture title: "Gender Variant/Transgender Youth: Endocrine Considerations")	Invited Plenary Lecture
2011	American Psychiatric Association (APA) Institutes on Psychiatric Services Annual Meeting (Presentation title: "The Child and Adolescent Gender Center: A UCSF/ Community Collaborative")	Invited speaker, panel presentation
2011	UCSF School of Medicine, Pediatric Interest Group: “Career Development in Pediatric Endocrinology"	Invited speaker
2012	Warren Alpert Medical School of Brown University Adult and Pediatric Grand Rounds, Providence, RI (Lecture title: "Gender Variant/Transgender Youth: Endocrine Considerations")	Invited lecture
2012	Endocrine Grand Rounds, UCSF School of Medicine, Department of Medicine, Division of Endocrinology, San Francisco, CA (Lecture title: "Gender Non-Conforming/Transgender Youth: Endocrine Considerations")	Invited lecture
2012	Gender Spectrum 6th Annual Family Conference (Lecture title: “The Biology of Gender”), Berkeley, CA	Invited lecture
2012	Gender Spectrum 6th Annual Family Conference (“Safe Sports for Transgender Youth"; "Medical Panel: Concerns for Transgender Youth"), Berkeley, CA	Invited speaker, panel presentations
2012	Gender Spectrum Professional's Workshop, Berkeley, CA (“The Use of Pubertal Blockers in Gender Variant Youth”)	Invited speaker
2012	UCSF School of Medicine, Pediatric Interest Group: “Career Development in Pediatric Endocrinology"	Invited speaker

2012	Pediatric Grand Rounds, Santa Clara Valley Medical Center, San Jose, CA (Lecture title: "Gender Non-Conforming/Transgender Youth: Endocrine Considerations")	Invited lecture
2013	Pediatric Grand Rounds, Children's Hospital of Philadelphia (CHOP), Philadelphia, PA, (Lecture title: "Gender Non-Conforming/Transgender Youth: Endocrine Considerations")	Invited lecture
2013	CHOP-Hospitals of the University of Pennsylvania (HUP) Combined Endocrine Grand Rounds, Philadelphia, PA, (Lecture title: "The Biology of Gender")	Invited lecture
2013	Pediatric Grand Rounds, Marin General Hospital, Greenbrae, CA (Lecture title: "Gender Nonconforming/Transgender Youth: Endocrine Considerations")	Invited lecture
2013	UCSF Trans Health Seminar	Invited lecture
2013	Pediatric Grand Rounds, John Muir Medical Center, Walnut Creek, CA (Lecture title: "Gender Nonconforming/Transgender Youth: Endocrine Considerations")	Invited lecture
2013	Grand Rounds, Children's Hospital & Research Center Oakland, Oakland, CA (Lecture title: "Gender Nonconforming/Transgender Youth: Endocrine Considerations")	Invited lecture
2013	Gender Spectrum 7th Annual Family Conference (Lecture title: “The Biology of Gender”), Berkeley, CA	Invited lecture
2013	Gender Spectrum Professional's Workshop, Berkeley, CA	Invited Lecture, Panel Presentations
2013	PFLAG, San Francisco Chapter	Invited speaker
2013	Expert Panel on Transgender Health for Adolescent Clients, Callen-Lorde Community Health Center, New York, NY	Invited speaker/panelist
2013	43rd Annual Fall Conference, Children's Hospital & Research Center Oakland, Monterey, CA (Lecture title: "Gender nonconforming/Transgender Youth: Endocrine Considerations")	Invited Lecture
2014	Medicine Grand Rounds, Beth Israel Medical Center, New York, NY (Lecture title: "Transgender Youth: Endocrine Considerations")	Invited Lecture
2014	UCSF Trans Health Seminar	Invited lecture

2014	Pediatric Grand Rounds and Visiting Professor, University of Wisconsin, Madison, WI (Lecture title: "Gender Nonconforming/Transgender Youth: Endocrine Considerations")	Invited Lecture and Visiting Professor
2014	Combined Adult/Pediatric Endocrine Grand Rounds, University of Wisconsin, Madison, WI (Lecture title; "The Biology of Gender")	Invited Lecture
2014	Kaiser Permanente CME: Transgender Care for the Pediatric Mental Health Provider (Lecture title: The Biology of Gender")	Invited Lecture/ Panelist
2014	Gender Spectrum 8th Annual Family Conference (Lecture title: “The Biology of Gender”), Moraga, CA	Invited lecture
2014	Gender Spectrum Professional's Workshop, Moraga, CA	Invited Lecture, Panel Presentations
2014	PFLAG Regional Convention, Napa, CA	Invited speaker
2014	47th Annual Clinical Advances in Pediatrics Symposium, Children's Mercy Hospital, Kansas City, MO (Lecture title: "Gender nonconforming/Transgender Youth: Endocrine Considerations")	Invited Keynote Address
2014	Endocrine Grand Rounds and Visiting Professor, University of Cincinnati Hospital Medical Center, Cincinnati, OH (Lecture title: Gender Nonconforming/Transgender Youth: Endocrine Considerations")	Invited Lecture and Visiting Professor

CONTINUING EDUCATION AND PROFESSIONAL DEVELOPMENT ACTIVITIES

2006	The Endocrine Society Annual Meeting
2006	The Lawson Wilkins Pediatric Endocrine Society Annual Meeting
2007	The Endocrine Society Annual Meeting
2007	The Lawson Wilkins Pediatric Endocrine Society Annual Meeting
2008	The Endocrine Society Annual Meeting
2008	The Lawson Wilkins Pediatric Endocrine Society Annual Meeting
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2014	The Pediatric Endocrine Society Annual Meeting
2014	Endocrine Society Annual Meeting
2015	Endocrine Society Annual Meeting
2015	The Pediatric Endocrine Society Annual Meeting

GOVERNMENT AND OTHER PROFESSIONAL SERVICE

1995 - 1995	USDA	Grant Review Panel
2006 - 2012	NIH/NIDDK, TrialNet Eligibility Committee	Member

UNIVERSITY AND PUBLIC SERVICE

SERVICE ACTIVITIES SUMMARY

As detailed above, the highlights of my service activities include the following: a) UCSF Campus-wide: I have served on the Committee for Human Research for 3 years was appointed to the UCSF LGBT Center of Excellence Task Force; b) School of Medicine: I was an inaugural lecturer in the 2nd year LifeCycle course and PISCES Preceptor for the 3rd year Pediatrics curriculum; c) Departmental Service: I have served on a variety of committees, most notably the Pediatric Ambulatory Clinic Operations Committee and the Pediatric Clinical Enterprise Committee. I served as the Pediatric Endocrine Clinic Director, the Pediatric Endocrine Director of the multi-disciplinary Disorders of Sex Development Clinic, and currently serve as Medical Director of the Child and Adolescent Gender Center. I also served as the Program Director for Pediatric Endocrinology Fellowship Training; and d) Public Service: My activities have focused on volunteering for the Visiting Nurses and Hospice program, volunteering for various Diabetes programs (family support groups, Diabetes camp, etc.), speaking at family conferences and professional workshops focused on the care of gender variant/ transgender youth and adolescents, and helping to raise money for financially challenged, promising figure skaters in the Bay Area.

UCSF CAMPUSWIDE

2000 - 2000	Search Committee for Division Chief, Reproductive Endocrinology	Member
2002 - 2003	Committee on Human Research	Member
2004 - 2006	Committee on Human Research	Member
2010 - 2010	Search Committee for Director, Mass Spectrometry Program	Member
2011 - present	UCSF LGBT Center of Excellence Task Force	Member

2012 - 2013	2013 National Trans Health Summit Planning Committee	Member
2014 - present	UCSF LGBT Leadership Collaborative on Education, Research, and Clinical Care	Member

SCHOOL OF MEDICINE

1994 - 2015	Various Ad hoc Promotion Review Committees	Member
1997 - 1999	Diabetes Center Planning Committee	Member
2002 - 2003	Life Cycle course, 2nd year Curriculum	Team Leader, Small Group Designer and Leader
2002 - 2015	Life Cycle course, 2nd year Curriculum	Lecturer (2)
2003 - 2007	Life Cycle course, 2nd year Curriculum	Small Group Designer and Leader
2004 - 2009	Foundations of Patient Care	Preceptor
2006 - 2007	UCSF Intersex Task Force	Member
2007 - 2014	Parnassus Integrated Student Clinical Experiences (PISCES), 3rd year Curriculum	Preceptor in Pediatrics (20 clinics/year)

SCHOOL OF DENTISTRY

2003 - 2015	Craniofacial Anomalies CFA 206	Lecturer

DEPARTMENTAL SERVICE

1986 - 1987	Intern Selection Committee	Member
1992 - 1993	Moffitt Ward Education Committee	Member
1993 - 1994	Endocrinology/Neurology/Neurosurgery/Hematology/Oncology, Panel A, Subspecialty Outpatient Rotation	Director
1993 - 2014	Intern Selection Committee	Member
2000 - 2000	Search Committee, Faculty Member, Division of Pediatric Endocrinology	Member
2006 - 2007	UCSF High School Summer Internship program	Preceptor/ Mentor
2006 - 2015	Pediatric Endocrine Outpatient Services	Director
2008 - 2009	Karlsberger Steering Committee	Member

2008 - 2011	Pediatric Endocrinolgy FellowshipTraining Program	Associate Program Director
2008 - present	Disorders of Sexual Development (DSD) Clinic	Pediatric Director
2009 - 2009	Ward Revision Task Force	Member
2009 - 2012	Outpatient Re-engineering Steering Committee	Member
2009 - 2010	Clinical Excellence Task Force, UCSF Pediatric Residency Program	Member
2010 - present	Child and Adolescent Gender Center	Medical Director and Steering Committee co-Chair
2011 - 2015	EPIC	"Superuser"
2012 - 2015	Pediatric Endocrinolgy FellowshipTraining Program	Program Director
2012 - 2015	Pediatric Ambulatory Clinic Operations Committee	Member
2012 - 2015	Pediatric Clinical Enterprise Committee	Member

COMMUNITY AND PUBLIC SERVICE

1991 - 2000	Visiting Nurses and Hospice of San Francisco	Volunteer, 1 evening/week
1995 - 2013	Diabetes Youth Foundation's Bearskin Meadow Summer Camp	Medical volunteer, 1 week/ year
1995 - 2002	Adult Skating Program Committee, US Figure Skating Association	Member
1996 - 1996	March of Dimes Walk Steering Committee, San Francisco, CA	Member
2000 - 2001	Skating Club of San Francisco	Member, Board of Directors, and Vice-President
2002 - 2012	Numerous Bay Area Diabetes Family Support Groups	Invited speaker
2007 - present	Skate San Francsco (Figure Skating Competition)	Medical volunteer
2008 - 2012	Diabetes Youth Foundation Annual Figure Skating event	Medical volunteer and Skating Instructor

2009 - present	Ice Bridges, a non-profit corporation which assists financially challenged, promising figure skaters in the San Francisco Bay Area	Member, Board of Directors
2010 - present	Bay Area Family Support Groups and Mental Health Professional Workshops for Gender Variant/ Transgender Youth and Adolescents	Invited speaker

CONTRIBUTIONS TO DIVERSITY

CONTRIBUTIONS TO DIVERSITY

I began my work with the care of gender nonconforming/transgender youth in January, 2009, and led efforts to create the multi-disciplinary Child and Adolescent Gender Center (CAGC), which formally opened its doors in May, 2012. I serve as Medical Director of the CAGC, serving >1300 gender nonconforming/ transgender youth, and oversee all clinical and research activities of the CAGC.

TEACHING AND MENTORING

TEACHING SUMMARY

In my current role as Emeritus Professor on Recall, I supervise postdoctoral fellows, residents, and medical students during one clinic/week (5-6 hr/wk). In addition, my current teaching responsibilities include: Lecturer in the Medicine/Pediatrics combined Endocrinology Fellows Course (2 hr); In addition to my UCSF teaching responsibilities, my teaching includes lecturing at a number of symposia on transgender health.

FORMAL TEACHING

	Academic Yr	Course No. & Title	Teaching Contribution	School	Class Size
	1986 - 2017	Adolescent Core Seminar Series 180.01C	Lecturer		
	2002 - 2015	Life Cycle, 2nd yr Med. Sch. Curr	Lecturer		Entire 2nd yr class
	2002 - 2007	Life Cycle, 2nd yr Med. Sch. Curr	Small Group Designer and Leader		25
	2003 - 2015	Craniofacial Anomalies CFA 206	Lecturer		
	2007 - 2014	Parnassus Integrated Student Clinical Experiences (PISCES), 3rd yr Med Sch Curr	Preceptor		1 student/ year

	Academic Yr	Course No. & Title	Teaching Contribution	School	Class Size
	2000 - 2009	Foundations of Patient Care IDS 132A	Preceptor		

INFORMAL TEACHING

1983 - 2015 Clinical: Weekly inpatient Pediatric Endocrine teaching conference: 1.5 hr/week x 48 weeks = 72 hr/year

1994 - present Clinical: Outpatient: Supervising/teaching: One clinic/week (5-6 hr) is a teaching clinic = 5-6 hr/week (including outpatient follow-up teaching) = 275 hr/year

MENTORING SUMMARY

I mentored Dr. Adi during his NIH K-08 Award in studies focused on understanding the molecular mechanisms through which Insulin-like Growth Factors influence the decision of skeletal myoblasts to proliferate or differentiate.
I mentored Dr. Cheung in clinical/translational studies investigating Aquaporin-2 excretion in the recently described Nephrogenic Syndrome of Inappropriate Antidiuresis.

PREDOCTORAL STUDENTS SUPERVISED OR MENTORED

Dates	Name	Program or School	Mentor Type	Role	Current Position
2003 - 2004	Dandan Liu	University of California, Berkeley		Supervised student for her Senior Honors Thesis	MD, Resident, UCSF
2007 - 2011	Linda Zhou, BS	Pre-doctoral student		Preceptor	Attending graduate school
2012 - 2012	Meaghan Pugh, RN, PNP	UCSF Advanced Practice Pediatric Nurse Practitioner Program		Clinical Preceptor	Clinical Practice
2013 - 2015	Tara Gonzalez	UC Berkeley-UCSF Joint Medical Program PRIME-US Program		Research Mentor	MS Class of 2015; MD Class of 2017

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POSTDOCTORAL FELLOWS AND RESIDENTS MENTORED

Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
1983 - 1984	Elizabeth Schriock, M.D	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Private Practice, San Francisco, CA
1983 - 1984	David Harris, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Assoc Clin Prof Pediatrics, U. of Utah, Salt Lake City
1983 - 1984	Leona Cuttler, M.D	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Professor and Chief of Pediatric Endocrinology, Case Western Reserve U., Cleveland, OH
1983 - 1984	Berthold Hauffa, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Professor of Pediatrics, Universitat Essen, Germany
1983 - 1984	Robert Lustig, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Professor of Clinical Pediatrics, UCSF
1983 - 1984	Klaus Rodens, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Assoc Prof Pediatrics, U. of Ulm, Germany
1983 - 1984	J. Anthony Hulse, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Consultant Endocrinologist, St. Thomas Hospital, London

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
1983 - 1985	Catherine Egli, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Chief of Pediatric Endocrinology, San Francisco Kaiser Hospital
1984 - 1985	David Stephure, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Assoc Prof Pediatrics and Chief of Pediatric Endocrinology, U. of Calgary, Canada
1984 - 1987	Bernard Silverman, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Former Assoc Prof and Chief of Ped Endo, Northwestern U., now Medical Director, Alkemes Inc.,
1984 - 1987	Jorge Daaboul, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Associate Professor of Pediatrics, U. of Florida, Gainesville, FL
1985 - 1987	Sharyn Solish, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Private Practice
1985 - 1988	Kenneth Attie, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Former Medical Director, Insmed Inc., Glen Allen, VA

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
1986 - 1988	Norbert Albers, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Assoc Prof, Children's Hospital, U. of Bonn, Germany
1986 - 1989	Carol Hart, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Asst Clin Prof Pediatrics, UC, San Diego, CA
1987 - 1989	Nelson Ramirez, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Deceased during fellowship
1987 - 1989	Stephen Gitelman, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Professor of Clinical Pediatrics, UCSF
1988 - 1988	Gregory Glasscock, Ph.D., M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Neonatologist
1988 - 1989	Carol Ishimatsu, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Private Practice, Downey, CA
1988 - 1989	Wen-Yu Tsai, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Assoc Prof of Pediatrics, Director, Pediatric Endocrinology, National Taiwan U.

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
1988 - 1988	Sushma Kaul, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Asst Clin Prof Pediatrics, Hackensack Medical Center, New Jersey
1989 - 1991	Klaus Hartmann, M.D.	Post-Doc Research Fellow		Laboratory Research Preceptor	Asst Prof Pediatrics, U. of Frankfurt, Germany
1989 - 1992	Juan Sanchez, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Assoc Prof Pediatrics, Indiana U. Medical Center, Indianapolis
1990 - 1992	Henry Rodriguez, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Associate Professor
1990 - 1993	David Paul, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Chief of Pediatric Endocrinology, David Grant Medical Center, Travis AFB, Sacramento, CA; Asst Clin Prof Pediatrics, UC, Davis
1990 - 1993	Lawrence Silverman, M.D.	Clinical and Research Fellow		Clinical and Laboratory Preceptor	Asst Prof Pediatrics, RWJ-UMDNJ, Chief of Ped Endo, Morristown Mem. Hosp.

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
1991 - 1994	Floyd Barry, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Training Chief for Pediatrics, McLennan Family Practice Residency Program, Waco, TX
1991 - 1994	Pat Mahachoklertwattana, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Assoc Prof Pediatrics; Chief of Pediatric Endocrinology, Mahidol U., Bangkok, Thailand
1993 - 1996	Debra Devoe, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Asst Clin Prof Pediatrics, U. Southern California and Los Angeles Children's Hospital, CA
1993 - 1996	David Geller, M.D., Ph.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Asst Prof Pediatrics, UCLA Cedars-Sinai Medical Center, Los Angeles, CA
1994 - 1996	Sudha Mootha, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Asst Prof Clin Pediatrics, U. Texas Southwestern Medical Center, Dallas
1994 - 1997	Saleh Adi, M.D.	Clinical and Research Fellow		Clinical and Laboratory Preceptor	H. S. Professor of Pediatrics, UCSF

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
1996 - 1999	Valérie Schwitzgebel, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Professor of Pediatrics, U of Geneva, Switzerland
1996 - 1998	Bassam Bin-Abbas, M.D.	Clinical and Research Fellow		Clinical and Laboratory Preceptor	Asst Prof Pediatrics, King Faisal U, Riyadh, Saudi Arabia
1998 - 1999	Peter Contini, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Private Practice, Moraga, CA
1998 - 2001	Louise Greenspan, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Pediatric Endocrinology, San Francisco Kaiser Hospital; Asst Clin Prof Pediatrics, UCSF
1998 - 2001	Jane Lee, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Clinical Research Scientist, Genentech Inc., South San Francisco, CA
1999 - 2002	Susan Conrad, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Formerly Attending Endocrinologist, Oakland Children's Hospital, Oakland, CA; Now in Private Practice

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
2000 - 2002	Chaluntorn Preeyasombat, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Asst Prof Pediatrics, Ramathibadi Hospital, Mahidol U., Bangkok Thailand
2001 - 2003	Nicola Tiffin, Ph.D.	Post-Doc Research Fellow		Laboratory Research Preceptor	Research Scientist, University of Western Cape, South Africa
2001 - 2004	Heidi Gassner, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Chief of Pediatric Endocrinology, Sacramento Kaiser Hospital
2002 - 2005	Qing Dong, M.D., Ph.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Chief of Pediatric Endocrinology, Chinese Hospital, San Francisco; Clinical Assistant Professor of Pediatrics, UCSF
2003 - 2007	Gary Meyer, Ph.D.	Post-Doc Research Fellow		Laboratory Research Preceptor	Private Industry
2003 - 2006	Eric Huang, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Attending Physician, Pediatric Endocrinology, Morristown Hospital, New Jersey

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
2004 - 2006	Brian J. Feldman, M.D.,Ph.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Assist. Prof of Pediatrics, Stanford U
2004 - 2006	Clement Cheung, M.D., Ph.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Assistant Adjunct Professor of Pediatrics, UCSF
2004 - 2007	Maureen A. Su, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Assistant Professor, Dept. of Pediatrics, U. of North Carolina
2005 - 2007	Andrew Bremer, M.D., Ph.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Assistant Professor of Pediatrics, Vanderbilt University, Nashville, TN
2005 - 2008	Sayali Ranadive, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Attending Formerly Endocrinologist, Oakland Children's Hospital, Oakland, CA; Now in Private Practice
2005 - 2007	Roger Long, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Asst Clinical Professor, UC Davis Medical Cntr

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
2006 - 2009	Alison Reed, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Attending Pediatric Endocrinologist, California Pacific Medical Center, San Francisco, CA
2007 - 2010	William Charlton, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Attending Physician, Joe DiMaggio Children's Hospital, Broward County, FL
2007 - 2010	Ivy Aslan, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Attending Endocrinologist, Oakland Children's Hospital, Oakland, CA
2008 - 2009	Jennifer Cordier, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Private Practice
2008 - 2010	Taninee Sahakitrungruang, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Assistant Prof of Pediatrics, Chuylalongkorn U, Bangkok, Thailand
2009 - 2011	Jenise Wong, M.D., Ph.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Instructor, UCSF

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
2009 - 2012	Thu Ho, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Private Practice
2009 - 2012	Anjali Jain, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Private Practice
2010 - 2013	Andrea Gerard Gonzalez, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Assistant Professor of Pediatrics, Barbara Davis Diabetes Center, Denver, CO
2010 - 2013	Lisa Taylor, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Private Practice
2010 - 2016	Stanley Vance, Jr., MD	Resident in Pediatrics; then Clinical Fellow, Adolescent Medicine		Research Mentor	Assistant Professor, UCSF
2011 - 2014	Amy Mugg, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	In Training
2011 - 2014	Sara Moassesfar, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	In Training

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
2012 - 2015	Priya Prahalad, M.D., Ph.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Assistant Professor, Stanford University
2012 - 2015	Joshua Tarkoff, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Clinical practice
2012 - 2015	Paula Jossan, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Clinical practice
2013 - 2014	Vanita Jindal, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Clinical practice
2013 - 2016	Nicholas Heiniger, M.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Clinical practice
2013 - 2016	Stanley Vance, Jr., M.D.	Clinical Fellow, Adolescent Medicine		Research Mentor	Assistant Professor, UCSF
2014 - present	Eric Bomberg, MD	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	In Training
2015 - 2019	Janet Lee, MD, MPH	Clinical Fellow, Pediatric Endocrinology		Clinical and Research Mentor	Instructor, UCSF

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Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
2015 - 2017	Liat Perl, MD	Clinical Fellow, Pediatric Endocrinology		Clinical and Research Mentor	In Training, Israel
2016 - 2019	Ayca Cakmak, MD	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	In Training
2016 - 2019	Alyssa Huang, MD	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Assistant Professor, University of Washington
2017 - present	Armaiti Mody, MD	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	In Training
2017 - present	Jenny Zabinsky, MD	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	In Training
2018 - present	Fatema Abdul Hussein, MD	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	In Training
2018 - present	Hannah Chesser, MD	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	In Training
2018 - present	Caroline Schulmeister, MD	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor and Research Mentor	In Training

Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
2019 - present	Isabella Niu, MD	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	In Training
2019 - present	Abby Cobb-Walch, MD	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor and Research Mentor	In Training

FACULTY MENTORING

Dates	Name	Position while Mentored	Mentor Type	Mentoring Role	Current Position
2010 - 2011	Clement Cheung, M.D., Ph.D.	Assistant Professor		Preceptor/ mentor for Aquaporin-2 research project and manuscript preparation	Assistant Adjunct Professor of Pediatrics, UCSF
2016 - 2017	Ensile Lee, MD	Assistant Professor, Korea		Preceptor/mentor in Child and Adolescent Gender Center	Assistant Professor, Korea
2016 - present	Stanley Vance, Jr., MD	Assistant Professor		Research Mentor	Assistant Professor, UCSF
2019 - present	Janet Lee, MD	Instructor		Research Mentor	Instructor, UCSF

RESEARCH AND CREATIVE ACTIVITIES

RESEARCH AND CREATIVE ACTIVITIES SUMMARY

My current research is focused on optimizing multidisciplinary care for transgender youth. I am currently serving as Principal Investigator (Multiple PI format) of an NIH/NICHD R01 focused on Early Medical Treatment of Transgender Youth, and as co-Investigator on two additional NIH R01's focused on transgender youth.

My prior research has included both basic science and clinical investigation. My laboratory work has focused on two aspects of hormone receptor signaling. First, we extended our work in Insulin-like Growth Factor (IGF)-I receptor signaling to studies in human neuroblastoma (NBL). Specifically, we have explored the role of IGF signaling in the growth, motility, and invasiveness of human NBL cells. In collaborative studies with UCSF investigators from Pediatric Oncology, Neurology, Internal Medicine, and Radiation Oncology, we have observed

that small molecule inhibitors of the IGF-I receptor block growth, survival, and motility of NBL cells, and inhibit NBL growth in vivo in a xenograft model in nude mice. A manuscript summarizing portions of this work has been published in the Journal of Cellular Biochemistry. This work has been supported by a grant from the Thrasher Research Fund with matching funds from the UCSF Cancer Center. I also received, as Principal Investigator, a Basic Research grant for our work regarding IGF-I signaling in neuroblastoma from the John A. Kerner, M.D. Research Foundation. Also as Principal Investigator, I have received a Basic Research grant from ImClone Systems, Inc., to examine the therapeutic potential of a humanized monoclonal anti-IGF-I receptor antibody and radiation in neuroblastoma.

In addition, we have recently identified and characterized novel activating mutations in the vasopressin V2 receptor (V2R) that cause a Syndrome of Inappropriate Antidiuretic Hormone (SIADH)-like phenotype, yet without detectable ADH. We have named this syndrome "Nephrogenic Syndrome of Inappropriate Antidiuresis" (NSIAD), and have reported our findings in New England Journal of Medicine 352:34-40, 2005 (co-first-author). I have been engaged in collaborative studies to extend our characterization of NSIAD, with three specific aims: 1) explore further the molecular mechanisms responsible for the constitutive activity of the vasopressin V2R mutants, 2) further characterize the clinical phenotype of NSIAD patients and heterozygous carriers, and 3) explore the potential role of selective vasopressin V2R "inverse agonists" as a targeted treatment for this condition. This work has been carried out in collaboration with investigators from the Departments of Psychiatry and Cellular and Molecular Pharmacology at UCSF, the Department of Biochemistry, Division of Cell Signaling and Molecular Pharmacology, at the University of Montreal, and the Department of Medicine, University of Colorado School of Medicine. A manuscript summarizing this work with respect to V2R trafficking waspublished in Molecular Pharmacology, 2010, and a manuscript summarizing this work with respect to urinary aquaporin-2 excretion in this syndrome has just been submitted for publication.

With respect to clinical investigation, I have been an investigator in studies related to Type 1 Diabetes, studies related to growth disorders, and studies related to disorders of sex development (DSD). With respect to Type 1 Diabetes, I served as co-Investigator for TrialNet, a multi-center NIH-sponsored study focused on developing therapies to prevent Type 1 Diabetes Mellitus in high risk individuals. I have been co-Investigator on the TrialNet Natural History of Type 1 Diabetes study and on five intervention studies for patients with newly diagnosed Type 1 Diabetes : 1) TrialNet Mycophenolate Mofetil-Dacluzimab (MMF-DZB), 2) TrialNet Rituximab, 3) TrialNet CTLA-4 Ig, 4) Immune Tolerance Network Phase II trial of hOKT3 gamma1 (Ala-Ala), and 5) Immune Tolerance Network trial of thymoglobulin. In addition, I have been Principal Investigator at UCSF for the TrialNet Nutritional Intervention to Prevent (NIP) Type 1 Diabetes study examining the therapeutic potential of docosahexaenoic acid, an omega-3 fatty acid, in individuals at high-risk for developing this disorder, and am co-Investigator in the TrialNet Oral Insulin Prevention Trial.

With respect to growth disorders, I have served as the UCSF-site Principal Investigator for a multi-center trial investigating the therapeutic potential of recombinant human IGF-I for prepubertal children with Growth Hormone (GH) resistance.

With respect to studies of DSD, I have served as co-Principal Investigator for a NIH/ NICHD R01 multi-center study entitled "Disorders of Sex Development: Platform for Basic and Translational Research". The focus of this project has been to develop a multi-site infrastructure to support hypothesis-based research on the mechanisms of sexual development and evidence-based care for patients with DSD and their families.

Effective April 1, 2011, I completed my basic laboratory work, shifting my research focus exclusively to clinical research. As noted above, my current research is focused on optimizing medical care of transgender youth, with particular emphasis on mental health and skeletal health outcomes of current treatment models.

RESEARCH AWARDS - CURRENT

1. 1R01HD082554-01A1	Principal Investigator (Multiple PI format)	20 % effort	Rosenthal (PI)
NIH/ NICHD		08/01/2015	06/30/2020
The Impact of Early Medical Treatment in Transgender Youth		$ 952,542 direct/yr 1	$ 5,732,531 total
This is a multicenter study which will be the first in the U.S. to evaluate the long-term outcomes of medical treatment for transgender youth. This study will provide essential, evidence-based information on the physiological and psychosocial impact, as well as safety, of hormone blockers and cross-sex hormones use in this population.			
2.	Principal Investigator	5 % effort	Rosenthal (PI)
San Francisco Department of Public Health		07/01/2017	06/30/2022
UCSF Child and Adolescent Gender Center Transgender Youth Support Program		$ 325,000 direct/yr 1	$ 1,625,000 total
To develop outreach and provide multidisciplinary services for transgender youth in the city of San Francisco			
Overall supervisor and consultant			
3. R01MH115349	Co-Investigator	10 % effort	Hong (PI)
NIH/ NIMH		07/01/2018	06/30/2023
Sex Hormone effect on Neurodevelopment: Controlled puberty in transgender adolescents			
This will be the first study of its kind to directly investigate longitudinal brain anatomy in young adolescents with gender dysphoria (GD). The study will utilize an innovative, cross-disciplinary approach that takes advantage of sophisticated imaging modalities to elucidate the interaction between sex hormone therapies and brain anatomy and connectivity in youth. Results from this interdisciplinary proposal will directly impact clinical care for individuals with GD and provide a much-needed empirical foundation for understanding the longitudinal impact of treatments that are already being used in clinical settings.			
Co-Investigator			
4. R01HD097122	Co-Investigator	3 % effort	Ehrensaft (PI)
NIH/ NICHD		03/21/2019	02/29/2024
Gender Nonconformity in Prepubescent Children: A Longitudinal Study			

This project is a prospective longitudinal observational study of pre-pubertal children who are gender-nonconforming and their care. It is a four-site study involving U.S.-based university affiliated pediatric gender clinics. With a targeted N of 320 subjects, the objective of the proposed research is to provide evidence-based data to inform clinical care for prepubescent transgender and gender-nonconforming children (TGNC).

Co-Investigator

RESEARCH AWARDS - PAST

1. Site Principal investigator

NIH: Clinical Associate Physician, General Clinical Research Center — 1984 — 1987

Growth Hormone Releasing Hormone in Hypopituitarism

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2. Principal investigator

Academic Senate Committee on Research, University of California San Francisco — 1987 — 1988

Insulin-like Growth Factors and Childhood Growth Disorders

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3. Principal Investigator

Grant Award, School of Medicine, Research Evaluation and Allocation Committee, University of California San Francisco — 1987 — 1988

Insulin-like Growth Factors and Childhood Growth Disorders

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4. Principal Investigator

NIH/NICHD: Clinical Investigator Award — 1988 — 1991

Insulin-like Growth Factors and Childhood Growth Disorders

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5. Principal Investigator

March of Dimes: Basil O'Connor Starter Scholar Research Award — 1989 — 1992

Insulin-like Growth Factors and Childhood Growth Disorders

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6. Principal Investigator

Academic Senate Committee on Research, University of California San Francisco — 1991 — 1992

Insulin-like Growth Factors and Skeletal Muscle Differentiation

7.		Principal Investigator		
	March of Dimes: Basic Research Grant		1992	1994
	Insulin-like Growth Factors and Skeletal Muscle Differentiation			
8.		Principal Investigator		
	NIH/NIDDK: FIRST Award		1992	1997
	Insulin-like Growth Factors and Skeletal Muscle Differentiation			$ 350,000 total
9.		Principal Investigator		
	March of Dimes: Basic Research Grant		1995	1997
	Insulin-like Growth Factors and Skeletal Muscle Differentiation			$ 101,150 total
10.		Principal Investigator		
	March of Dimes: Basic Research Grant		1997	1999
	Insulin-like Growth Factors and Skeletal Muscle Differentiation			$ 106,396 total
11.	R01 DK44181	Principal investigator		
	NIH/NIDDK		1998	2003
	IGFs and Skeletal Muscle Differentiation			$ 659,648 total
12.	HOE 9011/4030	Co-Principal Investigator		
	Aventis		2003	2004
	Morning Lantus vs. Intermediate-Acting Insulin in Adolescents with Type1 DM			$ 58,316 total
13.		Principal Investigator		
	Pfizer: Translational Basic Research Award		2003	2004

IGFs and Skeletal Muscle: Implications for Myotherapy $ 15,000 total

14. Co-Principal Investigator
Thrasher Research Fund 2005 2009
Targeted agents that synergize with radiation in high risk neuroblastoma $ 300,000 total

15. Principal Investigator
Tercica, Inc. 2005 2009
Recombinant Human Insulin-Like Growth Factor-I (rhIGF-I) Treatment of Short Stature Associated with Primary IGF-I Deficiency: A Multicenter, Open-Label, Randomized Concentration Controlled Trial $ 57,000 total

16. Principal Investigator
John A. Kerner, M.D. Foundation: Basic Research Award 2005 2009
Small Molecule Inhibitors of the IGF-I Receptor as a Potential Treatment for Neuroblastoma $ 41,500 total

17. 556830-26226 co-PI
NIH/NIAID 2005 2013
Thymoglobulin for treatment of new onset Type 1 Diabetes

18. Basic Research Award Principal Investigator
ImClone Systems, Inc. 2009 2011
The Therapeutic Potential of A12 Anti-IGF-IR Antibody and Radiation in Neuroblastoma $ 84,000 direct/yr 1

19. 23988-10 co-PI
NIH/NIDDK 2009 2013
UCSF TrialNet

20.	1R01HD068138-01A1	Site Principal Investigator	5 % effort	Vilain, Sandberg (PI)
	NIH/NICHD		09/26/2111	06/30/2016
	Disorders of Sex Development: Platform for Basic and Translational Research		$ 639,688 direct/yr 1	$ 3,198,340 total

21.		Principal Investigator	0 (See description, below) % effort	Rosenthal (PI)
	NIH/CTSI; Internal Award UCSF		06/01/2018	05/31/2019

Bone Density, Structure, and Estimated Strength in Transgender Youth Receiving Pubertal Suppression in Early Puberty

Minimal data exist on the skeletal effects of puberty suppression in early pubertal transgender youth. This longitudinal cohort study assessed bone mineral density by dual-energy x-ray absorptiometry and bone microarchitecture and strength by high-resolution peripheral quantitative computed tomography, as well as bone turnover markers, body composition, vitamin D status, weight-bearing exercise, and dietary calcium intake. These data will lead to longer-term studies and investigations of interventions to mitigate the expected lag in skeletal development during pubertal suppression. Ultimately, this research should positively contribute to the clinical care of transgender youth. This funding supported the above-noted studies carried out by postdoctoral fellow, Janet Y. Lee, MD, MPH.

Principal Investigator

PEER REVIEWED PUBLICATIONS

1. Rosenthal SM, Reid IA, Kaplan SL, Grumbach MM: Renin substrate depletion in salt-losing congenital virilizing adrenal hyperplasia: low plasma renin activity despite increased renin concentration.. J Pediatr l02:80-82, l983.
2. Rosenthal SM, Grumbach MM, Kaplan SL: Gonadotropin-independent familial sexual precocity with premature Leydig and germinal cell maturation ("familial testotoxicosis"): effects of a potent luteinizing hormone-releasing factor agonist and medroxyprogesterone acetate therapy in four cases. J Clin Endocrinol Metab 57:57l-579, l983.
3. Rosenthal SM, Schriock EA, Kaplan SL, Guillemin R, Grumbach MM: Synthetic human pancreas growth hormone-releasing factor (hpGRF 1-44-NH2) stimulates growth hormone secretion in normal men. J Clin Endocrinol Metab 57:677-679, l983.
4. Schriock EA, Lustig RH, Rosenthal SM, Kaplan SL, Grumbach MM: Effect of growth hormone (GH)-releasing hormone (GRH) on plasma GH in relation to magnitude and duration of GH deficiency in 26 children and adults with isolated GH deficiency or multiple pituitary hormone deficiencies: evidence for hypothalamic GRH deficiency. J Clin Endocrinol Metab 58:l043-l049, l984.

5. Egli CA, Rosenthal SM, Grumbach MM, Montalvo JM, Gondos B: Pituitary gonadotropin-independent male-limited autosomal dominant sexual precocity in nine generations: familial testotoxicosis. J Pediatr 106:33-40, 1985.

6. Gondos B, Egli CA, Rosenthal SM, Grumbach MM: Testicular changes in gonadotropin-independent familial male sexual precocity. Arch Pathol Lab Med 109:990-995, 1985.

7. Rosenthal SM, Hulse JA, Kaplan SL, Grumbach MM: Exogenous growth hormone inhibits growth hormone-releasing factor-induced growth hormone secretion in normal men. J Clin Invest 77:176-180, 1986.

8. Hulse JA, Rosenthal SM, Cuttler L, Kaplan SL, Grumbach MM: The effect of pulsatile administration, continuous infusion, and diurnal variation on the growth hormone (GH) response to GH-releasing hormone in normal men. J Clin Endocrinol Metab 63:872-878, 1986.

9. Rosenthal SM, Kaplan SL, Grumbach MM: Short-term continuous intravenous infusion of growth hormone (GH) inhibits GH-releasing hormone-induced GH secretion: a time-dependent effect. J Clin Endocrinol Metab 68:1101-1105, 1989.

10. Hartmann K, Papa V, Brown EJ, Rosenthal SM, Goldfine ID: A rapid and simple one-step method for isolation of Poly (A)+ RNA from cells in monolayer. Endocrinology 127:2038-2040, 1990.

11. Rabinovici J, Dandekar P, Angle M, Rosenthal SM, Martin M: Insulin-like growth factor I (IGF-I) levels in follicular fluid from human preovulatory follicles: correlation with serum IGF-I levels. Fertil Steril 54:428-433, 1990.

12. Rosenthal SM, Brunetti A, Brown EJ, Mamula PW, Goldfine ID: Regulation of insulin-like growth factor I (IGF-I) receptor expression during muscle cell differentiation: potential autocrine role of IGF-II. J Clin Invest 87:1212-1219, 1991.

13. Rosenthal SM, Silverman BL, Wehrenberg WB: Exogenous growth hormone (GH) inhibits bovine but not murine pituitary GH secretion in vitro: evidence for a direct effect of GH on the pituitary. Neuroendocrinology 53:597-600, 1991.

14. Rosenthal SM, Brown EJ, Brunetti A, Goldfine ID: Fibroblast growth factor inhibits insulin-like growth factor (IGF)-II gene expression and increases IGF-I receptor expression in BC3H-I myoblasts. Mol Endocrinol 5:678-684, 1991.

15. Papa V, Hartmann K, Rosenthal SM, Maddux BA, Siiteri PK, Goldfine ID: Progestins induce downregulation of insulin-like growth factor I receptors in human breast cancer cells: potential autocrine role of IGF-II. Mol Endocrinol 5:709-717, 1991.

16. Hartmann KKP, Baier TG, Papa V, Kronenwett M, Brown EJ, Goldfine ID, Rosenthal SM: A monoclonal anntibody to the T-cell receptor increases IGF-I receptor content in normal T-lymphocytes: Comparison with phytohemagglutinin. J Cell Biochem 48:81-85, 1992.

17. Brown EJ, Hsiao D, Rosenthal SM: Induction and peak gene expression of insulin-like growth factor II follow that of myogenin during differentiation of BC3H-1 muscle cells. Biochem Biophys Res Commun 183:1084-1089, 1992.

18. Goodman PA, Sbraccia P, Brunetti A, Wong KY, Carter JD, Rosenthal SM, Goldfine ID: Growth factor receptor regulation in the Minn-1 Leprechaun: defects in both insulin receptor and epidermal growth factor receptor gene expression. Metabolism 41:504-509, 1992.

19. Goldfine ID, Papa V, Vigneri R, Siiteri P, Rosenthal SM: Progestin regulation of insulin and insulin-like growth factor I receptors in cultured human breast cancer cells. Breast Cancer Res Treat 22:69-79, 1992.

20. Uyeki T, Barry FL, Rosenthal SM, Mathias RS: Successful treatment with hydrochlorothiazide and amiloride in an infant with congenital nephrogenic diabetes insipidus. Pediatric Nephrology 7:554-556, 1993.

21. Rosenthal SM, Brown EJ: Mechanisms of insulin-like growth factor (IGF)-II-induced IGF-I receptor down-regulation in BC3H-1 muscle cells. J Endocrinology 141:69-74, 1994.

22. Rosenthal SM, Hsiao D, Silverman LA: An insulin-like growth factor (IGF)-II analog with highly selective affinity for IGF-II receptors stimulates differentiation but not IGF-I receptor down-regulation in muscle cells. Endocrinology 135:38-44, 1994.

23. Silverman LA, Cheng Z-Q, Hsiao D, Rosenthal SM: Skeletal muscle cell-derived insulin-like growth factor (IGF) binding proteins inhibit IGF-I-induced myogenesis in rat L6E9 cells. Endocrinology 136:720-726, 1995.

24. Rosenthal SM, Cheng Z-Q: Opposing early and late effects of insulin-like growth factor-I on differentiation and the cell cycle regulatory retinoblastoma protein in skeletal myoblasts. Proc Natl Acad Sci USA 92:10307-10311, 1995.

25. Burch GH, Bedolli MA, McDonough S, Rosenthal SM, Bristow J: Embryonic expression of Tenascin-X suggests a role in limb, muscle, and heart development. Dev Dyn 203:491-504, 1995.

26. Hernández-Sánchez C, Werner H, Roberts Jr CY, Woo EJ, Hum D, Rosenthal SM, LeRoith D: Differential regulation of insulin-like growth factor-I (IGF-I) receptor gene expression by IGF-I and basic fibroblast growth factor. JBiol Chem 272:4663-4670, 1997.

27. Rabinovici J, Cataldo NA, Dandekar P, Rosenthal SM, Gargosky SE, Gesundheit N, Martin MC: Adjunctive growth hormone during ovarian hyperstimulation increases levels of insulin-like growth factor binding proteins in follicular fluid: A randomized, placebo-controlled, crossover study. J Clin Endocrinol Metab 82:1171-1176, 1997.

28. Devoe DJ, Miller WL, Conte FA, Kaplan SL, Grumbach MM, Rosenthal SM, Wilson CB, Gitelman SE: Long-term outcome in children and adolescents following transsphenoidal surgery for Cushing disease. J Clin Endocrinol Metab 82:3196-3202,1997.

29. Adi S, Cheng Z-Q, Zhang P-L, Wu NY, Mellon SH, Rosenthal SM: Opposing early inhibitory and late stimulatory effects of insulin-like growth factor-I on myogenin gene transcription. J Cell Biochem 78:617-626, 2000.

30. Cheng Z-Q, Adi S, Hsiao D, Woo EJ, Filvaroff EH, Gustafson TA, Rosenthal SM: Functional inactivation of the insulin-like growth factor-I receptor delays differentiation of skeletal muscle cells. J Endocrinology 167:177-184, 2000.

31. Roll U, Turek CW, Gitelman SE, Rosenthal SM, Nolte MS, Masharani U, Ziegler A-G, Baekkeskov S: Peptide mapping and characterization of glycation patterns of the glima 38 antigen recognized by autoantibodies in Type I diabetic patients. Diabetologia 43:598-608, 2000.

32. Adi S, Wu NY, Rosenthal SM: Growth factor-stimulated phosphorylation of Akt and p70S6K is differentially inhibited by LY294002 and wortmannin. Endocrinology 142:498-501, 2001.

33. Adi S, Bin-Abbas B, Wu NY, Rosenthal SM: Early stimulation and late inhibition of Erk ½ phosphorylation by IGF-I: a potential mechanism mediating the switch in IGF-I action on skeletal muscle differentiation. Endocrinology 143:511-516, 2002.

34. Wilson TA, Rose SR, Cohen P, Rogol AD, Backeljauw P, Brown R, Hardin DS, Kemp SF, Lawson M, Radovick S, Rosenthal SM, Silverman L, Speiser P. Update of guidelines for the use of growth hormone in children: The Lawson Wilkins Pediatric Endocrinology Society Drug and Therapeutics Committee. J Pediatr 143:415-421, 2003.

35. Tiffin N, Adi S, Stokoe D, Wu NY, Rosenthal SM: Akt phosphorylation is not sufficient for IGF-stimulated myogenin expression, but must be accompanied by downregualtion of Erk 1/2 phosphorylation. Endocrinology 145:4991-4996, 2004.

36. Feldman BJ*, Rosenthal SM*, Vargas GA, Fenwick RG, Huang EA, Matsuda-Abedini M, Lustig RH, Mathias RS, Portale AA, Miller WL, Gitelman SG: Nephrogenic syndrome of inappropriate anitdiuresis. N Engl J Med 352:34-40, 2005.
* Denotes co-first author

37. Huang EA, Feldman BJ, Schwartz ID, Geller DH, Rosenthal SM, Gitelman SE: Oral urea for the treatment of chronic syndromes of inappropriate antidiuresis in children. J Pediatr 148:128-131, 2006.

38. Meyer GE, Chesler L, Liu D, Youngren J, Goldfine ID, Weiss WA, Matthay KK, Rosenthal SM: Nordihydroguaiaretic acid inhibits insulin-like growth factor signaling, growth and survival in human neuroblastoma cells. J Cell Biochem 102:1529-1541, 2007.

39. Bremer AA, Feldman BJ, Clark OH, Rosenthal SM: Report of a Hurthle cell thyroid neoplasm in a peripubertal girl. Thyroid 17:175-178, 2007.

40. Bremer AA, Ranadive S, Conrad SC, Vallette-Kasic S, Rosenthal SM: Isolated adrenocorticotrophin deficiency presenting as an acute neurologic emergency in a prepubertal girl. J Ped Endocrinol Metab 21:799-803, 2008.

41. Cohen P, Rogol AD, Deal CL, Saenger P, Reiter EO, Ross JL, Chernausek SD, Savage MO, Wit JM on behalf of the 2007 ISS Consensus Workshop participants (SM Rosenthal included among named participants in this group): Consensus Guidelines for the Diagnosis and Treatment of Children with Idiopathic Short Stature: A Summary Statement of the Growth Hormone Research Society in Association with the Lawson Wilkins Pediatric Endocrine Society and the European Society for Pediatric Endocrinology. J Clin Endocrinol Metab 93:4210-4217, 2008.

42. Ranadive SA, Ersoy E, Favre H, Cheung CC, Rosenthal SM, Miller WL, Vaisse C: Identification, characterization and rescue of a novel vasopressin-2 receptor mutation causing nephrogenic diabetes insipidus. Clin Endocrinol 71:388-393, 2009.

43. Chase HP, Lescheck E, Rafkin-Mervis L, Krause-Steinrauf H, Chritton S, Asare SM, Adams S, Skyler JS, Clare-Salzler M and the Type 1 Diabetes TrialNet NIP Study Group (Rosenthal SM included among participants in this group): Nutritional Intervention to prevent (NIP) Type 1 Diabetes: A Pilot Trial. ICAN: Infant, Child, & Adolescent Nutrition 1:98-107, 2009.

44. Pescovitz MD, Greenbaum CJ, Krause-Steinrauf H, Becker DJ, Gitelman SE, Goland R, Gottlieb P, Marls JB, McGee PF, Moran AM, Raskin P, Rodriguez H, Schatz DA, Wherrett D, Wilson DM, Lachin JM, Skyler JS, for the Type 1 Diabetes TrialNet Anti-CD20 Study Group (Rosenthal SM included among named participants in this group): Rituximab, B-

lymphocyte depletion, and preservation of beta-cell function. N Engl J Med 361:2143-2152, 2009.

45. Rochdi MD, Vargas GA, Carpentier E, Oligny-Longpre G, Chen S, Kavoor, A, Gitelman SE, Rosenthal SM, von Zastrow M, Bouvier M: Functional characterization of vasopressin type 2 receptor substitutions (R137H/C/L) leading to nephrogenic diabetes insipidus and nephrogenic syndrome of inappropriate antidiuresis: Implications for treatments. Mol Pharmacol 77:836-845, 2010.

46. Cho YH, Gitelman S, Rosenthal S, Ambler G. Long-term outcomes in a family with nephrogenic syndrome of inappropriate antidiuresis. Int J Pediatr Endocrinol 2009:431527. Epub 2010 Jan 28.

47. Aslan IR, Baca EA, Charlton W, Rosenthal SM: Respiratory syncytial virus (RSV) infection as a precipitant of thyroid storm in a previously undiagnosed case of Graves disease in a prepubertal girl. Int J Pediatr Endocrinol 2011:138903. Epub 2011 Mar 22.

48. Wherrett DK, Bundy B, Becker DJ, MiMeglio LA, Gitelman SE, Goland R, Gottlieb PA, Greenbaum CJ, Herold KC, Marks JB, Monzavi R, Moran A, Orban T, Palmer JP, Raskin P, Rodriguez H, Schatz D, Wilson DM, Krischer JP, Skyler JS, Type 1 Diabetes TrialNet GAD Study Group (Rosenthal SM included among named participants in this group): Antigen-based therapy with glutamic acid decarboxylase (GAD) vaccine in patients with recent onset type 1 diabetes: a randomized double-blind trial. Lancet 378(9788):319-327, 2011.

49. Orban T, Bundy B, Becker DJ, DiMeglio LA, Gitelman SE, Goland R, Gottlieb PA, Greenbaum CJ, Marks JB, Monzavi R, Moran A, Raskin P, Rodriguez H, Russell WE, Schatz D, Wherrett D, Wilson DM, Krischer JP, Skyler JS; Type 1 Diabetes TrialNet Study Group (Rosenthal SM included among named participants in this group): Co-stimulation modulation with abatacept in patients with recent-onset type 1 diabetes: a ranomized, double-blind, placebo-controlled trial. Lancet 378(9789):412-419, 2011.

50. Pescovitz MD, Torgerson TR, Ochs HD, Ocheltree E, McGee P, Krause-Steinrauf H, Lachin JM, Canniff J, Greenbaum C, Herold KC, Skyler JS, Weinberg A; Type 1 Diabetes trialNet Study Group (Rosenthal SM included among named participants in this group): Effect or rituximab on human in vivo antibody immune responses. J Allergy Clin Immunol 128 (6):1295-1302, 2011

51. Cheung CC, Cadnapaphornchai MA, Ranadive SA, Gitelman SE, Rosenthal SM: Persistent elevation of urine Aquaporin-2 during water loading in a child with Nephrogenic Syndrome of Inappropriate Antidiuresis (NSIAD) caused by a R137L mutation in the V2 Vasopressin receptor. Int J Pediatr Endocrinol 3:1-6, 2012

52. Yu L, Boulware DC, Beam CA, Hutton JC, Wenzlau JM, Greenbaum CJ, Bingley PJ, Krischer JP, Sosenko JM, Skyler JS, Eisenbarth GS, Mahon JL; Type 1 Diabetes TrialNet Study Group (Rosenthal SM included among named participants in this group): Zinc transporter-8 autoantibodies improve prediction of type 1 diabetes in relatives positive for the standard biochemical antibodies. Diabetes Care 35 (6):1213-1218, 2012

53. Herold KC, Gitelman SE, Willi SM, Gottlieb PA, Waldron-Lynch F, Devine L, Sherr J, Rosenthal SM, Adi S, Jalaludin MY, Michels AW, Dziura J, Bluestone JA: Teplizumab treatment may improve C-peptide responses in participants with type 1 diabetes after the new onset period: a randomized controlled trial. Diabetologia 56 (2):391-400, 2013

54. Kroll JL, Beam C, Li S, Viscidi R, Dighero B, Cho A, Boulware D, Pescovitz M, Weinberg A; Type 1 Diabetes TrialNet Anti CD-20 Study Group (Rosenthal SM included among named particpants in this group): Reactivation of latent viruses in individuals receiving rituximab for new onset type 1 diabetes. J Clin Virol 57 (2):115-119, 2013

55. Moran A, Bundy B, Becker DJ, DiMeglio LA, Gitelman SE, Goland R, Greenbaum CJ, Herold KC, Marks JB, Raskin P, Sanda S, Schatz D, Wherett DK, Wiolson DM, Krischer JP, Skyler JS; Type 1 Diabetes Trialnet Canakinumab Study Group (Rosenthal SM included among named participants in this group), Pickersgilol L, de Koning E, Ziegler AG, Boehm B, Badenhoop K, Schloot N, Bak JF, Pozzilli P, Mauricio D, Donath MY, Castano L, Wagner A, Lervang HH, Perrild H, Mandrup-Poulsen T; AIDA Study Group. Interleukin-1 antagonism in type 1 diabetes of recent onset: two multicentre, randomised, double-blind, placebo-controlled trials. Lancet 381 (9881):1905-1915, 2013

56. Sosenko JM, Skyler JS, Palmer JP, Krischer JP, Yu L, Mahon J, Beam CA, Boulware DC, Rafkin L, Schatz D, Eisenbarth G; Type 1 Diabetes TrialNet Study Group (Rosenthal SM included among named participants in this group); Diabetes Prevention Trial-Type 1 Study Group. The prediction of type 1 diabetes by multiple autoantibody levels and their incorporation into an autoantibody risk score in relatives of type 1 diabetic patients. Diabetes Care 36 (9):2615-2620, 2013

57. Sosenko JM, Skyler JS, Beam CA, Krischer JP, Greenbaum CJ, Mahon J, Rafkin LE, Matheson D, Herold KC, Palmer JP; Type 1 Diabetes TrialNet and Diabetes Prevention Trial-Type 1 Study Groups (Rosenthal SM included among named participants in this group). Acceleration of the loss of the first-phase insulin response during the progression to type 1 diabetes in diabetes prevention trial-type 1 participants. Diabetes 62 (12):4179-4183, 2013

58. Hidalgo MA, Ehrensaft D, Tishelman AC, Clark LF, Garofalo R, Rosenthal SM, Spack NP, Olson J. The gender affirmative model: What we know and what we aim to learn. Human Development 56:285-290, 2013

59. Vance S, Ehrensaft D, Rosenthal SM. Psychological and medical care of gender nonconforming youth. Pediatrics 134 (6):1184-1192, 2014

60. Lazure P, Bartel RC, Biller BMK, Molitch ME, Rosenthal SM, Ross JL, Bernsten BD, Hayes SM. Contextualized analysis of a needs assessment using the Theoretical Domains Framework: A case example in endocrinology. BMC Health Services Research 14:319-332, 2014

61. Rosenthal SM. Approach to the Patient: Transgender Youth: Endocrine Considerations. J Clin Endocrinol Metab 99 (12):4379-4389, 2014

62. Lee PA, Wisniewski A, Baskin L, Vogiatzi MG, Vilain E, Rosenthal SM, Houk C. Advances in diagnosis and care of persons with DSD over the last decade. Int J Pediatr Endocrinol, 2014, in press.

63. Vance S, Halpern-Felsher B, Rosenthal SM. Health care providers' comfort with and barriers to care of transgender youth. J Adolesc Health 56 (2):251-253, 2015

64. Haller M, Gitelman S, Gottlieb P, Michels A, Rosenthal SM, Shuster J, Zou B, Brusko T, Hulme M, Wasserfall C, Mathews C, Atkinson M, Schatz D. ATG and G-CSF Preserve Beta Cell Function in Established Type 1 Diabetes. J Clin Invest 125 (1):448-455, 2015

65. Sherer I, Baum J, Ehrensaft D, Rosenthal SM. Affirming gender: Caring for gender-atypical children and adolescents. Contemporary Pediatrics 32 (1):16-19, 2015

66. Olson-Kennedy J, Cohen-Kettenis PT, Kreukels BP, Meyer-Balburg HF, Garofalo R, Meyer W, Rosenthal SM. Research priorities for gender nonconforming/transgender youth: Gender identity development and biopsychosocial outcomes. Curr Opin Endocrinol Diabetes Obes 23 (2):172-179., 2016

67. Rosenthal SM. Transgender Youth: Current concepts. Ann Pediatr Endocrine Metab 21 (4):185-192, 2016

68. Vance SR Jr, Deutsch MB, Rosenthal SM, Buckelew SM. Enhancing pediatric trainees' and students' knowledge in providing care to transgender youth. J Adolesc Health 60 (4):425-430, 2017

69. Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, Rosenthal SM, Safer JD, Tangpricha V, T'Sjoen GG. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society Clinical Practice Guideline. J Clin Endocrine Metab 102 (11):3869-3903, 2017

70. Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, Rosenthal SM, Safer JD, Tangpricha V, T'Sjoen GG. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society Clinical Practice Guideline. Endocr Practice 23 (12):1437, 2017

71. Vance SR, Rosenthal SM. A Closer Look at the Psychosocial Realities of LGBTQ Youth. Pediatrics. 2018 05; 141(5). PMID: 29661942

72. Ehrensaft D, Rosenthal SM. Sexual Assault Risk and School Facility Restrictions in Gender Minority Youth. Pediatrics. 2019 06; 143(6). PMID: 31061221

73. Rosenthal SM, Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, Safer JD, Tangpricha V, T'Sjoen GG. Response to Letter to the Editor: PMID: 31046093

74. Olson-Kennedy J, Chan YM, Garofalo R, Spack N, Chen D, Clark L, Ehrensaft D, Hidalgo M, Tishelman A, Rosenthal S. Impact of Early Medical Treatment for Transgender Youth: Protocol for the Longitudinal, Observational Trans Youth Care Study. JMIR Res Protoc. 2019 Jul 09; 8(7):e14434. PMID: 31290407. PMCID: PMC6647755

75. Bangalore Krishna K, Fuqua JS, Rogol AD, Klein KO, Popovic J, Houk CP, Charmandari E, Lee PA, Freire AV, Ropelato MG, Yazid Jalaludin M, Mbogo J, Kanaka-Gantenbein C, Luo X, Eugster EA, Klein KO, Vogiatzi MG, Reifschneider K, Bamba V, Garcia Rudaz C, Kaplowitz P, Backeljauw P, Allen DB, Palmert MR, Harrington J, Guerra-Junior G, Stanley T, Torres Tamayo M, Miranda Lora AL, Bajpai A, Silverman LA, Miller BS, Dayal A, Horikawa R, Oberfield S, Rogol AD, Tajima T, Popovic J, Witchel SF, Rosenthal SM, Finlayson C, Hannema SE, Castilla-Peon MF, Mericq V, Medina Bravo PG. Use of Gonadotropin-Releasing Hormone Analogs in Children: Update by an International Consortium. Horm Res Paediatr. 2019; 91(6):357-372. PMID: 31319416

76. Olson-Kennedy J, Chan YM, Rosenthal S, Hidalgo MA, Chen D, Clark L, Ehrensaft D, Tishelman A, Garofalo R. Creating the Trans Youth Research Network: A Collaborative Research Endeavor. Transgend Health. 2019; 4(1):304-312. PMID: 31701011. PMCID: PMC6830532

REVIEW ARTICLES

1. Gitelman SE, Feldman BJ, Rosenthal SM: Nephrogenic syndrome of inappropriate antidiuresis: A novel disorder in water balance in pediatric patients. Am J Med 119:S54-S58, 2006.
2. Rosenthal SM, Feldman BJ, Vargas GA, Gitelman SE: Nephrogenic syndrome of inappropriate antidiuresis (NSIAD): A paradigm for activating mutations causing endocrine disease. Pediatr Endocrinol Rev Volume 4, Suppl 1:66-70, 2006
3. Rosenthal SM, Gitelman SE, Vargas GA, Feldman BJ: Gain-of-function mutations in the V2 vasopressin receptor. Horm Res 67: Suppl. 1: 121-125, 2007.
4. Rosenthal S, Cohen P, Clayton P, Backeljauw P, Bang P, Ten S: Treatment perspectives in Idiopathic Short Stature with a focus on IGF-I deficiency (Guest Editor: Rosenfeld RG). Pediatr Endocrinol Rev Volume 4, Suppl 2: 251-271, 2007.
5. Rosenthal SM: Treatment approaches for growth failure: Statement 4: Therapy should be offered to children with idiopathic short stature (ISS) whose heights are <-2.25 standard deviation (SD) score: Evidence pro and con. Pediatr Endocrinol Rev Volume 5, Suppl 3:847-52, 2008.
6. Sherer I, Rosenthal, SM, Ehrensaft D, Baum J: Child and Adolescent Gender Center: A multidisciplinary collaboration to improve the lives of gender nonconforming children and teens. Pediatrics in Review 33:273-275, 2012

BOOKS AND CHAPTERS

1. Rosenthal SM, Schriock EA, Van Vliet G, Silverman BL, Kaplan SL, Grumbach MM: Growth hormone-responsive short stature: current and prospective treatment. In: Therapeutic Agents Produced by Genetic Engineering: Quo Vadis? The Example of Growth Hormone and Its Releasing Factor. Joyeau A, Leygue G, Morre M, Roncucci R, Schmelck PH (eds). Quo Vadis? Symposium, Toulouse-Labege, France. Sanofi Recherche, Montpellier, France, 1986, pp 325-334.
2. Schriock EA, Rosenthal SM, Egli CA, Harris DA, Hauffa BP, Hulse JA, Lustig RH, Kaplan SL, Grumbach MM: Studies with growth hormone releasing factor (GRF) in the human: effect of a single pulse, continuous infusion or multiple pulses of GRF on growth hormone (GH) release in normal and GH deficient children and adults. In: Human Growth Hormone. Raiti S and Tolman RA (eds), Plenum NY, 1986, pp 387-403.
3. Rosenthal SM, Grumbach MM: The Neuroendocrinology of Puberty: Recent Advances. In: Major Advances in Human Female Reproduction. Adashi EY, Mancuso S (eds), Raven Press, NY, 1990, pp 25-34.
4. Rosenthal SM, Wilson DW: Pediatric Endocrinology. In: Rudolph's Fundamentals of Pediatrics, Rudolph AM, Kamei R (eds), Appleton & Lange, Norwalk, 1994, Chapt 19, pp 583-615.
5. Rosenthal SM, Hsiao D, Cheng Z-Q, Silverman LA: Insulin-like growth factors and muscle cell differentiation. In: The Insulin-like Growth Factors and Their Regulatory Proteins, Baxter RC, Gluckman PD, Rosenfeld RG (eds), Excerpta Medica, Amsterdam, 1994, pp 275-282.

6. Rosenthal SM, Gitelman SE: Pediatric Endocrinology. In: Rudolph's Fundamentals of Pediatrics, Rudolph AM, Kamei R (eds), Appleton & Lange, Stamford, Connecticut,1998, Chapt 20, pp 641-683.
7. Rosenthal SM: Insulin-like growth factors and skeletal muscle. In: The IGF System: Molecular Biology, Physiology and Clinical Applications, Rosenfeld RG, Roberts Jr. CT (eds), Humana Press, Inc.,Totowa,1999, pp 497-516.
8. Rosenthal SM, Gitelman SE: Pediatric Endocrinology. In: Rudolph's Fundamentals of Pediatrics, Rudolph AM, Kamei R, Overby KJ (eds), McGraw-Hill, NY, 2002, Chapt 19, pp 747-795.
9. Dong Q, Rosenthal SM: Endocrine Disorders of the Hypothalamus and Pituitary. In: Pediatric Neurology, Fourth Edition, Swaiman KF, Ashwal S, Ferriero DM (eds), Mosby, Inc. (Elsevier, Inc.), Philadelphia, PA, 2006, pp. 2113-2127.
10. Ranadive S, Rosenthal SM: Pediatric Disorders of Water Balance. Endocrinol Metab Clin North Am 38:663-672, 2009.
11. Ranadive S, Rosenthal SM: Pediatric Disorders of Water Balance. Pediatr Clin North Am 58:1271-1280, 2011.
12. Dong Q, Rosenthal SM: Endocrine Disorders of the Hypothalamus and Pituitary in Childhood and Adolescence. In: Swaiman's Pediatric Neurology, Fifth Edition, Swaiman KF, Ashwal S, Ferriero DM, Schor NF (eds), (Saunders), Elsevier, Inc., Philadelphia, PA, p. 1690-1702, 2012.
13. Masters SB, Rosenthal SM: Hypothalamic & Pituitary Hormones. In: Basic and Clinical Pharmacology, Twelfth Edition, (Lange), The McGraw-Hill Companies, Inc., New York, NY, p. 659-679, 2012.
14. Bonifacio HJ, Rosenthal SM: Gender Variance and Dysphoria in Children and Adolescents. Pediatr Clin Noth Am 62 (4):1001-1016, 2015
15. Rosenthal SM. Transgender Youth: Endocrine Management. In Principles of Transgender Medicine and Surgery, 2nd Ed., Ettner R, Monastery S, Coleman E, eds., p. 208-221, 2016
16. Rosenthal SM, Hembree WC. Transgender Endocrinology. In Greenspan's Basic & Clinical Endocrinology, 10th Ed., Gardner DG, Shoback D, eds., p. 771-782, 2018
17. Lee JY, Perl L, Rosenthal SM. Care of Gender Nonconforming/ Transgender Youth. In Radovick and Misra's Pediatric Endocrinology: A Practical Clinical Guide, 3rd Ed., Misra M, Radovick S, eds., 2018, in press
18. Perl L, Lee JY, Rosenthal SM. Medical Side Effects of GnRH Agonists. In Pubertal Suppression in Transgender Youth, Finlayson C, ed. 2018, in press

OTHER PUBLICATIONS

1. Gitelman SE, Feldman BJ, Rosenthal SM: Nephrogenic syndrome of inappropriate antidiuresis – Reply (Letter). N Engl J Med 355:530, 2005.
2. Vance SR Jr, Ehrensaft D, Rosenthal SM. Authors' response. Pediatrics 135 (5):1366-1367, 2015

3. Vance SR, Jr, Rosenthal SM. Treating transgender youth: Pushing the dialog forward. J Adolesc Health 57 (4):357-358, 2015.

4. Lopez X, Marinkovic, Eimicke T, Rosenthal SM, Olshan JS; Pediatric Endocrine Society Transgender Health Special Interest Group. Statement on gender-affirmative approach to care from the Pediatric Endocrine Society Special Interest Group on Transgender Health. Curt Opin Pediatric 29 (4):475-480, 2017.

SIGNIFICANT PUBLICATIONS

1. Feldman BJ*, Rosenthal SM*, Vargas GA, Fenwick RG, Huang EA, Matsuda-Abedini M, Lustig RH, Mathias RS, Portale AA, Miller WL, Gitelman SE: Nephrogenic syndrome of inappropriate antidiuresis. N Engl J Med 352:34-40, 2005.
   * Denotes co-first author

   I was co-first author on this publication. I recognized that a child, suspected to have a primary renal salt-losing condition, instead had a problem of disordered water balance, and oversaw an evaluation (clinical and laboratory) which ultimately led to the discovery of a novel activating mutation of the V2 vasopressin receptor (V2R) in one of the first of two patients with this previously undescribed disorder. In addition, I co-supervised the data analysis and co-wrote the manuscript.

2. Huang EA, Feldman BJ, Schwartz ID, Geller DH, Rosenthal SM, Gitelman SE: Oral urea for the reatment of chronic syndromes of inappropriate antidiuresis in children. J Pediatr 148:128-131, 2006.

   I co-supervised the study design and data analysis and co-wrote the manuscript.

3. Meyer GE, Chesler L, Liu D, Youngren J, Goldfine ID, Weiss WA, Matthay KK, Rosenthal SM: M Nordihydroguaiaretic acid inhibits insulin-like growth factor signaling, growth and survival in human neuroblastoma cells. J Cell Biochem 102:1529-1541, 2007.

   I co-designed the studies, supervised the experiments in my laboratory, oversaw the data analysis, and co-wrote the manuscript.

4. Rosenthal S, Cohen P, Clayton P, Backeljauw P, Bang P, Ten S: Treatment perspectives in Idiopathic Short Stature with a focus on IGF-I deficiency (Guest Editor: Rosenfeld RG). Pediatr Endocrinol Rev Volume 4, Suppl 2: 251-271, 2007

   I was the principal author in the data analysis and in the writing of the manuscript.

5. Ranadive SA, Ersoy E, Favre H, Cheung CC, Rosenthal SM, Miller WL, Vaisse C: Identification, characterization and rescue of a novel vasopressin-2 receptor mutation causing nephrogenic diabetes insipidus. Clin Endocrinol epub ahead of print: 2008, Dec. 18.

   I contributed to experimental study design and co-wrote the manuscript.

6. Rochdi MD, Vargas GA, Carpentier E, Oligny-Longpre G, Chen S, Kavoor, A, Gitelman SE, Rosenthal SM, von Zastrow M, Bouvier M: Functional characterization of vasopressin type 2 receptor substitutions (R137H/C/L) leading to nephrogenic diabetes insipidus and nephrogenic syndrome of inappropriate antidiuresis: Implications for treatments. Mol Pharmacol 77:836-845, 2010.

   I proposed the collaboration and contributed to the experimental design and the writing of the manuscript.

7. Cheung CC, Cadnaphaporhornchai MA, Ranadive SA, Gitelman SE, Rosenthal SM. Persistent elevation of urine aquaporin-2 during water loading in a child with Nephrogenic Syndrome of Inappropriate Antidiuresis (NSIAD) caused by a R137L mutation in the V2 vasopressin receptor. /> Int J Pediatr Endocrinol 3:1-6, 2012

   I proposed the study, co-designed the experiments, oversaw the data analysis, and co-wrote the manuscript.

CONFERENCE ABSTRACTS

1. Note: The following are abstracts from the year 2000 onward:

   Wu,NY, Adi S**,** Rosenthal SM: The proliferative and differentiation responses to IGF-I in skeletal myoblasts are influenced by cell density. The Endocrine Society, 2000.

2. Adi S, Wu NY, Rosenthal SM: Early stimulation and late inhibition of Erk1/2 phosphorylation mediate, at least in part, the time-dependent opposing effects of IGF-I on myogenin gene expression. The Endocrine Society, 2001.

3. Adi S, Wu NY, Rosenthal SM: The Role of the MAPK(Erk1/2) Pathway in mediating the switch in IGF-I action from inhibition to stimulation of myogenic differentiation. Sixth Joint Meeting of the European Society for Pediatric Endocrinology and the Lawson Wilkins Pediatric Endocrine Society, Montreal, Canada. 2001.

4. Tiffin N, Rosenthal SM: Upregulation of serum response factor expression by IGF-I is mediated by Erk1/2 phosphorylation in skeletal myoblasts. The Endocrine Society, 2002.

5. Tiffin N, Adi S, Wu NY, Rosenthal SM: Akt phophorylation is insufficient and Erk1/2 dephosphorylation is necessary for IGF-induced myogenesis. First Joint Symposium GH-IGF 2002, Boston, MA, 2002.

6. Meyer GE, Gable K, Liu D, Youngren J, Goldfine ID, Rosenthal SM: Small molecule inhibitors of the insulin-like growth factor I receptor block neuroblastome growth, survival, and motility. The Endocrine Society, 2004.

7. Feldman BJ, Rosenthal SM, Vargas GA, Fenwick RG, Huang EA, Matsuda-Abedini M, Miller WI, Gitelman SE: Pseudo-SIADH: Identification of novel activating mutations in the V2 Vasopressin receptor causing a new genetic disease. The European Society of Pediatric Endocrinology, 2004.

8. Meyer GE, Chesler L, Liu D, Bach LA, Bar RS, Youngren J, Kerner J, Goldfine ID, Weiss WA, Matthay KK, Rosenthal SM: Small molecule inhibitors of the Insulin-like Growth Factor I receptor are pro-apoptotic and inhibit neuroblastoma growth in vivo. The Endocrine Society, 2005.

9. Vargas G, Chen S, Feldman B, Rosenthal S, Gitelman S, von Zastrow M: Characterization of a novel activating mutation in the V2 Vasopressin receptor causing the Nephrogenic Syndrome of Inappropriate Antidiuresis. The Endocrine Society, 2005.

10. Cheung CC, Cadnapaphornchai MA, Ranadive SA, Gitelman SE, Rosenthal SM: Persistent elevation of urine Aquaporin-2 during water loading in a child with Nephrogenic Syndrome of Inappropriate Antidiuresis (NSIAD). The Endocrine Society, 2007.

11. Meyer GE and Rosenthal SM: Combined anti-proliferative effects of Insulin-like Growth Factor Binding Protein-3 and Nordihydroguaiaretic acid on neuroblastoma cells in vitro. The Endocrine Society, 2007.

12. Ranadive SA, Ersoy B, Favre H, Cheung CC, Rosenthal SM, Miller WL, Vaisse C: A novel V2 vasopressin receptor (V2R) mutation causing X-linked Nephrogenic Diabetes Insipidus (NDI). The Endocrine Society, 2008.

13. Aslan IPR, Davis KR, Baca E, Charlton W, Kussmaul S, Winnicki E, Arnold T, Chan A, Rosenthal SM: Respiratory Syncytial Virus (RSV) Infection as a precipitant of thyroid storm in a previously undiagnosed case of Graves' disease in a prepubertal girl. The Endocrine Society, 2008.

14. Zhou L, Maddux BA, Goldfine ID, Yang X, Haas-Kogan DA, Ludwig DL, Rosenthal SM: Insulin-like Growth Factor-I receptor signaling blockade combined with radiation inhibits human neuroblastoma proliferation. The Endocrine Society, 2009.

EXHIBIT 4

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER; BRIANNA BOE, individually and on behalf of her minor son, MICHAEL BOE; JAMES ZOE, individually and on behalf of his minor son, ZACHARY ZOE; MEGAN POE, individually and on behalf of her minor daughter, ALLISON POE; KATHY NOE, individually and on behalf of her minor son, CHRISTOPHER NOE; JANE MOE, Ph.D.; and RACHEL KOE, M.D.

Plaintiffs,

v.

KAY IVEY, in her official capacity as Governor of the State of Alabama; STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama; DARYL D. BAILEY, in his official capacity as District Attorney for Montgomery County; C. WILSON BAYLOCK, in his official capacity as District Attorney for Cullman County; JESSICA VENTIERE, in her official capacity as District Attorney for Lee County; TOM ANDERSON, in his official capacity as District Attorney for the 12th Judicial Circuit; and DANNY CARR, in his official capacity as District Attorney for Jefferson County.

Defendants.

Civil Action No.

_____

DECLARATION OF REV. PAUL A. EKNES-TUCKER IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER & PRELIMINARY INJUNCTION

I, Paul A. Eknes-Tucker, declare as follows:

1. I am the Senior Pastor at Pilgrim Church in Birmingham, Alabama. I have been a pastor for forty-five years and worked in congregations across the United States.

2. Seven years ago, I was honored to be called to serve the congregation at Pilgrim Church. This calling also allowed me to return to Alabama, the state where I was born and raised.

3. Pilgrim Church was established in Birmingham in 1903 and is part of the United Church of Christ. We hold services every Sunday and open our church during the week for events and community gatherings.

4. A core tenet of this congregation is to love and support all people to be their true selves. This is a belief that I talk about while performing my duties as a Senior Pastor. In fact, my sermon on Easter Sunday this year touched on supporting and caring for the transgender young people in our communities.

5. In my role as Senior Pastor, I have also provided pastoral counseling to parents of transgender children who are church congregants as well as to members of the Birmingham community. In those counseling discussions, parents are often uncertain about what guidance their religious faith can provide as they figure out how to support their child and how their faith can sustain them through that process.

We often talk about their children being made in the image of God and about the role of parents in helping and supporting their children.

6. While providing pastoral counseling, parents of transgender children will often share their worries and fears as well as hopes and aspirations for their transgender child's future. Some of the questions they have relate to the application of our faith's teachings to and the spiritual effects of medical treatments for gender dysphoria. My goal in those conversations is to answer their questions and provide information that the parents would find useful in guiding their decisions about their child's medical care. My religious faith compels me to support parents to love and affirm their transgender children. This includes counseling parents to get help from medical and mental health professionals, when needed, to assist and care for their children and to embrace who they are.

7. I have been fortunate to continue working with the families of transgender children for whom I have provided pastoral counseling. Watching parents support their child, I have seen improvements in the mental health and wellbeing of their children, but also as a family unit; their commitment to one another and their faith only grew stronger.

8. Given my understanding of Alabama's Vulnerable Child Compassion and Protection Act (SB 184), I am concerned that I could face criminal penalties or

fines for my work as a pastoral counselor, which could "cause" a transgender minor to begin receiving medical treatment for their gender dysphoria.

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

Executed this 19 th day of April, 2022.

Rev. Paul A. Eknes-Tucker

EXHIBIT 5

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER; BRIANNA BOE, individually and on behalf of her minor son, MICHAEL BOE; JAMES ZOE, individually and on behalf of his minor son, ZACHARY ZOE; MEGAN POE, individually and on behalf of her minor daughter, ALLISON POE; KATHY NOE, individually and on behalf of her minor son, CHRISTOPHER NOE; JANE MOE, Ph.D.; and RACHEL KOE, M.D.

Plaintiffs,

v.

KAY IVEY, in her official capacity as Governor of the State of Alabama; STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama; DARYL D. BAILEY, in his official capacity as District Attorney for Montgomery County; C. WILSON BAYLOCK, in his official capacity as District Attorney for Cullman County; JESSICA VENTIERE, in her official capacity as District Attorney for Lee County; TOM ANDERSON, in his official capacity as District Attorney for the 12th Judicial Circuit; and DANNY CARR, in his official capacity as District Attorney for Jefferson County.

Defendants.

Civil Action No.
_____

DECLARATION OF BRIANNA BOE, IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER & PRELIMINARY INJUNCTION

I, Brianna Boe,[1] declare as follows:

1. I am plaintiff to this action and the mother of Michael Boe, a twelve-year-old transgender boy and another plaintiff in this action.

2. I am a citizen of Alabama and reside with Michael in Montgomery County, Alabama.

3. As a young child, Michael was very care-free and outgoing. He was just a happy kid. Then, when Michael was about nine years old, I noticed a significant change in his behavior. He became depressed, withdrew from his friends, and became more anxious and impatient. He also started acting out in school and struggled academically. Some mornings he would beg not to go to school. Although I still took him, I could see that he was both sad and afraid.

4. I talked with him to try to figure out what was going on. He told me that he was starting to feel different and like he didn't belong, and that he was not like other girls. Michael worried that other kids were judging him, and he told me that he was getting bullied a lot at school.

5. Worried that his stress and anxiety was interfering with this ability to learn, I placed him in a new school the following year and started taking him to see

[1] Because of concerns about criminal liability and my child's privacy and safety, I am seeking to proceed in this case under a pseudonym. *See Motion to Proceed Pseudonymously*, filed concurrently herewith. In addition, contemporaneous with signing this declaration, I have signed with my legal name a separate copy of this declaration. My attorneys have a copy of that separate declaration.

a therapist, who helped Michael begin untangling what was causing his depression. Seeing this therapist helped Michael, but he had still not returned to his old self. Over the following year, he regularly talked to me about his growing awareness of his male gender identity. I could see that this was something that occupied a lot of his mental energy and that navigating the mismatch between his inner sense of who he is and the way others saw him was very stressful for him.

6. At the same time, Michael started going through puberty. His chest, and eventually his period, caused him a lot of anxiety and further fueled his depression. Michael would dread getting his period every month—and still does. He finds it very difficult to go to school—let alone pay attention—during the first few days of his period every month. For Michael, this discomfort is far beyond any sort of normal adjustment or discomfort that a non-transgender adolescent might experience. He is anguished, and often debilitated, by these physical reminders that his body does not match who he knows himself to be.

7. About a year ago, in June 2021, Michael disclosed to me that he is transgender. I was happy that he felt comfortable sharing this with me, and I let him know that I love and support him in being who he is. I also was scared because I saw what the bullying had done to him before and knew that his peers may not be accepting of him. Setting that fear aside, I looked for resources to learn what I needed to know to best support Michael, including making sure that he was seen by

healthcare providers with experience working with kids like him. I wanted to be sure that Michael was getting the best possible treatment and that I would have experts who could answer my questions and advise me about treatment options.

8. Soon after Michael came out as transgender to me, I told Michael's father, his siblings, and extended family that Michael is transgender. As I expected, his father was initially taken aback, but we talked about it, and he took the time to learn about transgender children and the importance of supporting them. After that, he came around quickly and has been supportive of Michael ever since. Michael's siblings and grandparents have been equally supportive.

9. I also started taking Michael to see a second therapist who specializes in working with adolescents experiencing gender dysphoria. The therapist confirmed that Michael has gender dysphoria and recommended that he be evaluated for medical treatment. At the same time, with the support of his therapist and family, Michael began to socially transition. Coming out as transgender and socially transition had a remarkably positive effect on Michael, but because he has not yet been able to start any medical treatments for his gender dysphoria, the conflict between his male identity and his body causes him a lot of distress.

10. Although he doesn't have a large chest, his breasts cause him significant distress. He wears a binder everyday to flatten his chest as much as possible, which he couples with baggy clothes to further hide the contour of his

chest. If he could, he would wear his binder all the time, but it is not recommended to wear a binder more than 8-10 hours each day. As a compromise, I bought him numerous sports bras with different levels of compression for him to wear when he takes the binder off. He relies on those sports bras almost as much as his binder. Michael cannot sleep without wearing a sports bra.

11. Michael's period also continues to be a source of significant distress for him. We keep track of his cycles in hopes that he will be mentally prepared, but no amount of preparation or notice is enough. Every month his depression and anxiety spikes, like clockwork.

12. Michael is working hard to manage his depression and recently started taking medication to treat his mental health. Still, there are days that those coping mechanisms fail him due to the intense distress caused by his gender dysphoria. He has engaged in self-harm, such as cutting, and has had suicidal ideation, which I have learned is common among transgender adolescents who are unable to receive the medical treatments they need.

13. Unfortunately, his school environment has become unwelcoming. Recently, he was cornered by a group of students who insisted that Michael was not a boy. Although his teacher addressed the situation afterwards, most of his teachers have not been that supportive, regularly referring to him by the wrong name or pronouns.

14. In February 2022, I called the gender clinic at Children's Hospital to make an initial appointment for Michael. The first availability they had was in December 2022. If this law goes into effect, Michael will not even be able to be evaluated for medical treatment for his gender dysphoria.

15. I am worried that if law prevents Michael from receiving medical evaluation and care for his gender dysphoria that the hormones in his body will continue to change his body in ways that are inconsistent with his gender identity and that his mental health will decline rapidly. Knowing that he has an appointment at the gender clinic has given him hope. Taking that way will leave him with therapy and mental health medications, which we have already seen are not able to adequately address his gender dysphoria. The fact that Michael has a history of cutting and prior suicidal ideation makes even more worried for his safety and wellbeing. One of my other children lost a transgender friend to suicide and I cannot let that happen to Michael.

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

Executed this 19th day of April, 2022.

Brianna Boe

Brianna Boe

EXHIBIT 6

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER; BRIANNA BOE, individually and on behalf of her minor son, MICHAEL BOE; JAMES ZOE, individually and on behalf of his minor son, ZACHARY ZOE; MEGAN POE, individually and on behalf of her minor daughter, ALLISON POE; KATHY NOE, individually and on behalf of her minor son, CHRISTOPHER NOE; JANE MOE, Ph.D.; and RACHEL KOE, M.D.

Plaintiffs,

v.

KAY IVEY, in her official capacity as Governor of the State of Alabama; STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama; DARYL D. BAILEY, in his official capacity as District Attorney for Montgomery County;; C. WILSON BAYLOCK, in his official capacity as District Attorney for Cullman County; JESSICA VENTIERE, in her official capacity as District Attorney for Lee County TOM ANDERSON, in his official capacity as

Civil Action No. _____

DECLARATION OF JAMES ZOE IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

District Attorney for Coffee County; and DANNY CARR, in his official capacity as District Attorney for Jefferson County.

Defendants.

I, James Zoe,[1] hereby declares as follows:

1. I am a citizen of Alabama and reside with my wife and our son in Jefferson County, Alabama.

2. My son, Zachary Zoe, is a thirteen-year-old transgender boy and is another plaintiff in this action. He is in the seventh grade, a bright boy with a close group of friends, and is interested in video games and art. He hopes to become a mental health professional one day.

3. I was born and raised in Alabama, attended the University of Alabama at Birmingham, and have been living in Birmingham my entire life. My wife resided in Alabama from 2009 to 2011, and she returned in 2018. We met that year and married in 2020. Alabama is our family's home and we want to stay here.

[1] Because of concerns about criminal liability and my child's privacy and safety, I am seeking to proceed in this case under a pseudonym. *See* Motion to Proceed Pseudonymously, filed contemporaneously herewith. In addition, contemporaneous with signing this declaration, I have signed with my legal name a separate copy of this declaration. My attorneys have a copy of that separate declaration.

4. When my wife and I married, my wife became Zachary's stepmother, and she has been his champion ever since they met. We share custody and co-parent with Zachary's biological mother and stepfather who also live in Alabama. They fully support the decision to fight for Zachary in court.

5. Zachary was born in Alabama and, like me, has lived in this state for his entire life. Zachary resides half-time with me and my wife in Jefferson County, and half-time with his biological mother and stepfather in St. Clair County. Alabama is Zachary's home and he too, plans to continue residing here.

6. Zachary was assigned female at birth. As a younger child, Zachary was shy and reserved. Around the age of 8, Zachary began to dislike wearing dresses and bright clothing, especially if the clothing was pink. Over time, Zachary started to prefer dressing in masculine attire more and more strongly. He became distressed if people identified him as a girl.

7. Around a year later when Zachary was 9 years old, he started female puberty. Zachary was distressed that he was developing breasts and had to confront menstrual cycles. This caused him to become withdrawn. Around the age of 10, Zachary became uncomfortable wearing any kind of clothing that revealed his body. For example, he started to wear boys' athletic shorts and t-shirts instead of girls' bathing suits when going to swim. As his parents, we did not initially understand why he was withdrawn or why he was so uncomfortable with his body.

8. When Zachary was 11 years old, he began referring to himself using "he" and "him" pronouns. In response, some of his friends mirrored his use of male pronouns. Identifying with male pronouns brought Zachary a greater sense of self-awareness, self-acceptance, allowing him to feel more at ease and happy. It was also when Zachary was 11 years old that he formally told me, my wife, his biological mother, and his stepfather that he is a transgender boy. He declared to us that he did not want to be identified as female. He told us that he uses he/him pronouns and wants us to call him by his chosen name. We all love our Zachary and were supportive of him.

9. Zachary's social transition has been very positive for him. He uses a chest binder and appears and dresses like other boys his age. His friends and his teachers refer to him using "he" and "him" pronouns. It is important to his mental health and well-being that others around him see him as the boy he is. After he came out, Zachary has blossomed into a happier and more outgoing child.

10. In October 2021, after completing appropriate mental health evaluations, Zachary began taking puberty-blocking medication, prescribed by his pediatrician with the support of both sets of parents. He just recently had an appointment to start the assessment process for hormone therapy at the Children's Hospital of Alabama at Birmingham.

11. Continued access to puberty-blockers is essential to maintain Zachary's current state of mental health. It is also critical that he continues on a steady path of receiving future treatments that are age-appropriate and medically necessary to address gender dysphoria. This law has caused my family enormous anxiety. If it goes into effect, we will be forced to choose between harming our son by denying him medically necessary care or facing criminal prosecution. I know the rates of suicide that run through the transgender population due to discrimination and harassment, and I am terrified that this law will exacerbate my son's anxiety and push him into self-harm.

12. None of the decisions surrounding Zachary's medical care have been easy. But the one decision that has not been difficult is to listen and talk to Zachary and engage in regular conversations with medical professionals to determine what course of treatment would be appropriately tailored for my son.

13. I am concerned for Zachary's mental health and well-being if his gender-affirming treatments are disrupted, suspended, or discontinued. No parent should have to watch their child experience severe, unnecessary distress, and this law will do just that because its enforcement and implementation will cause Zachary to develop irreversible physical traits that are inconsistent with his male identity. I am concerned that being forced to undergo this harmful experience will have a

lasting negative effect on Zachary's future and irreparably jeopardize his chance to lead a healthy, happy life as an adult.

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

Executed this 19th day of April, 2022 in Jefferson County, Alabama.

James Zoe

EXHIBIT 7

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER; BRIANNA BOE, individually and on behalf of her minor son, MICHAEL BOE; JAMES ZOE, individually and on behalf of his minor son, ZACHARY ZOE; MEGAN POE, individually and on behalf of her minor daughter, ALLISON POE; KATHY NOE, individually and on behalf of her minor son, CHRISTOPHER NOE; JANE MOE, Ph.D.; and RACHEL KOE, M.D.

Plaintiffs,

v.

KAY IVEY, in her official capacity as Governor of the State of Alabama; STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama; DARYL D. BAILEY, in his official capacity as District Attorney for Montgomery County; C. WILSON BAYLOCK, in his official capacity as District Attorney for Cullman County; JESSICA VENTIERE, in her official capacity as District Attorney for Lee County; TOM ANDERSON, in his official capacity as District Attorney for the 12th Judicial Circuit; and DANNY CARR, in his official capacity as District Attorney for Jefferson County.

Defendants.

Civil Action No.
_____

DECLARATION OF MEGAN POE IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER & PRELIMINARY INJUNCTION

I, Meagan Poe,[1] hereby declare as follows:

1. I am a plaintiff to this action and the mother of Allison Poe, another plaintiff in this action.

2. I was born and raised in Cullman County, Alabama. Other than the years that my ex-husband, Allison's father, was a member of the United States Army and stationed outside Alabama, I have lived in Cullman County along with my extended family.

3. Allison is a fifteen-year-old transgender girl. Allison was identified as male at birth, but, as her father and I have come to understand, she has a female gender identity. I know that if she could force herself to live as a boy, she would, but that is simply not possible for her. It is who she is.

4. Allison started showing an interest in girls' toys around the age of two. We were stationed overseas at the time and most of her friends were girls because most kids her age on the army base were girls. As a result, she would regularly play with her friends' typical "girls' toys" and wear princess dresses, but we would not buy her girls' toys or clothing. She begged us to buy her a Barbie doll and we refused. Without consulting us, however, her grandmother eventually bought her a Barbie

[1] Because of concerns about criminal liability and my child's privacy and safety, I am seeking to proceed in this case under a pseudonym. *See Motion to Proceed Pseudonymously*, filed concurrently herewith. In addition, contemporaneous with signing this declaration, I have signed with my legal name a separate copy of this declaration. My attorneys have a copy of that separate declaration.

doll. Allison carried that Barbie everywhere she went; it was like a teddy bear to her. Although we were not happy that Allison's grandmother bought the Barbie, we figured this was phase that would pass after we left that base. At most, we thought this was a clear sign that Allison would grow up to be gay.

5. We returned to the United States when Allison was approximately four years old. While stationed at the new base, Allison's interest in girls' clothing and toys persisted. Every time we went shopping for clothes, she would cry that I would not buy her clothes from the girls' section. Because Allison's grandmother already bought her a doll, I figured it would be okay to allow her to have some girls' toys. Knowing that her father wouldn't approve, I bought her a few small dolls and other toys that she could play with while her father was at work. Allison's father eventually found the toys and threw them all away, but her older brother then snuck outside and pulled them out of the garbage for Allison.

6. I eventually started working as a babysitter for a local family with kids close to Allison's age. The mother of that family was nurse and after observing Allison over time, she commented to me that Allison might be transgender. Before that day, I had never heard the word transgender. I did a little research into it but did not follow up much further because Allison's father was not accepting of her, and I still strongly believed that Allison would grow up to be gay.

7. After completing his assignment, Allison's father decided to leave the Army and was honorably discharged. We returned to Cullman County, Alabama to be closer to family. Unfortunately, soon after relocating, we legally separated and I was left to raise two kids on my own as a single working parent.

8. While around her cousins, Allison started doing more boys' activities, like playing video games. I thought maybe Allison was just growing up and that her girl phase was coming to an end. But that could not have been further from the truth.

9. Over the next few years, Allison's personality changed significantly. She became very quiet, showed signs of depression, and regularly commented that she wanted to die. She also stopped eating regularly. All of that was very concerning to me, but Allison would not share with me what was causing that change. Then, towards the end of Allison's fourth-grade year, when she was nine years old, I found a drawing she made of herself. On one side of the drawing was a crying boy and on the other was a happy girl. Around that same time, one of my family members pointed out to me that Allison was not really playing video games; she had been spending the majority of the time perfecting her female avatars on each of the games she was "playing."

10. Not sure what to make of all this, and at my wits end about how to help Allison, I took her to see her pediatrician. After evaluating Allison and talking with us about what had been going on, the pediatrician reiterated what I had heard from

that nurse years prior: Allison may be transgender. She then referred Allison to the gender clinic at UAB in Birmingham for specialized care and assessment.

11. While Allison was being evaluated by a team of clinicians at UAB, I finally got a sense of the emotional issues Allison had been trying to deal with on her own. For example, Allison earnestly asked Dr. Abdul-Latif why God hates her. Faith has always been a very important part of my life and that of our family. Hearing her ask that question broke my heart, both because I wanted Allison to have a strong tie to her faith and because I recognized that my actions as her parent likely contributed to her feeling that way.

12. Because Allison had not yet started puberty, there was no medical treatment for Allison's gender dysphoria, but Dr. Abdul-Latif and the other medical and mental health providers at the clinic gave me information about my options and recommendations about how to support Allison and treat her gender dysphoria. The clinic also connected Allison with regular mental health treatment.

13. That was a turning point for me. I had been very nervous about publicly supporting Allison's transition because I was worried about how our family—and the broader community—would respond. But, I quickly pushed those feelings aside, knowing that I had to do what was right for my child based on the advice of experts.

14. After returning from the appointment at UAB, I made an appointment for Allison to fix her hair into more of a girls' style while she grew it out. We also

cleaned out Allison's room of all boys' clothes, toys, bedding, and decorations, and I took Allison shopping to entirely redo her bedroom and wardrobe. Once we finished setting up her new room, I left her in the room so she could change into one of her new outfits. It is not an exaggeration to say that I saw a totally different child come out of that bedroom moments later. Allison was beaming. She was smiling and happy in a way that I had not seen for a long time.

15. The following night I e-mailed my family to update them about Allison's transition. My family took a long time to process that announcement and some family members initially cut ties with us.

16. The remaining few weeks of Allison's fourth-grade year were equally challenging. She experienced bullying from her classmates who were confused or did not understand Allison's transition and why it was so critical to her health and wellbeing. It was a painful time, but even through all those challenges, Allison remained resilient, further confirming that supporting her in this way was the right decision.

17. Over the summer between Allison's fourth and fifth grade, I had multiple meetings with school administrators and Allison's teachers regarding Allison's transition. We worked together to ensure that she received the supports she needed when she returned to school for fifth grade to prevent further bullying and

allow her to focus on learning. Those efforts largely worked; Allison was generally accepted by her peers and had a much better school experience than in prior years.

18. During Allison's fifth-grade year, some of her peers started showing the first signs of puberty. Allison became very scared about what would happen when she began puberty. Around that same time, we had a follow up appointment at the gender clinic at UAB. The purpose of the visit was to assess whether Allison had begun puberty and to gather more information about possible treatments for Allison's gender dysphoria once she begins puberty. I came to the appointment prepared with a list of questions and notebook to take notes. Allison and I asked many questions about puberty-blocking medications. As the providers answered our questions, I could see the relief in Allison's face when she realized that there was a solution to her worries about puberty. Given the distress Allison was already having around puberty, it was important to me that I got all the information I needed to make an informed decision so that I was prepared with my decision when that time came.

19. The providers at the UAB clinic patiently answered each of our questions during that initial follow up visit. We had several more follow up visits at UAB and in each of those visits, we asked any additional questions about puberty-blocking medications that had come to mind in the months between visits. Thus, when the doctors determined that Allison had started puberty at the end of sixth

grade, I had all the information I needed to consent to Allison starting puberty-blocking medication and did so without hesitation.

20. Because of the puberty-blockers, Allison has been able to have a typical childhood. Allison loves art and is creative. She is also an avid gamer, playing both for the entertainment and camaraderie with fellow gamers.

21. Approximately seven months ago, Allison started taking estrogen. As with puberty-blockers, the clinic at UAB answered all our questions and made sure that we understood the risks, benefits, and alternatives of hormone-replacement therapy. Allison self-administers her dose of estrogen and medication to suppress her testosterone.

22. Allison's mental health has improved dramatically since starting estrogen. She used to be very self-conscious, but now she is confident in herself and excited by all the changes in her body. She has grown new friendships and is doing well in school.

23. Without medical treatment all Allison's fears around developing an Adam's apple, facial hair, and other defining features of male puberty would become her reality. Her appearance would not align with who she is and would likely disclose to everyone that she is transgender, causing her extreme anxiety and distress and exposing her to more ridicule and harassment.

24. Seeing Allison's response to the Alabama legislature's consideration of the Act and knowing how afraid she is of male puberty, I am very worried that Allison's mental health would quickly deteriorate if the Act goes into effect. As much as I want to assure Allison that we would find a way to get her the medications she needs to treat her gender dysphoria—medications that are critical to her ability to function—I don't know if it would be possible. We receive our health insurance coverage through Alabama Medicaid. Although I would drive Allison anywhere so that she could get those medications, we cannot afford to pay for them out of pocket and I don't know if Alabama Medicaid would cover out-of-state providers or prescriptions written by those providers.

25. Stopping or delaying Allison's medical treatments for her gender dysphoria will be devastating to her overall health and wellbeing. I worry that Allison will be inconsolable and retreat into herself. Once the medications wear off, I have little doubt that I will have to bring Allison back to UAB and that she will have to be admitted for in-patient psychiatric care to prevent her from harming herself or worse. And I know that will only be the beginning, it is hard to imagine what the long-term effects will be on her day-to-day life, but I am certain that she will no longer be the same happy child that she is today.

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

Executed this 19 th day of April, 2022.

Megan Poe

Megan Poe

EXHIBIT 8

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER; BRIANNA BOE, individually and on behalf of her minor son, MICHAEL BOE; JAMES ZOE, individually and on behalf of his minor son, ZACHARY ZOE; MEGAN POE, individually and on behalf of her minor daughter, ALLISON POE; KATHY NOE, individually and on behalf of her minor son, CHRISTOPHER NOE; JANE MOE, Ph.D.; and RACHEL KOE, M.D.

Plaintiffs,

v.

KAY IVEY, in her official capacity as Governor of the State of Alabama; STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama; DARYL D. BAILEY, in his official capacity as District Attorney for Montgomery County; C. WILSON BAYLOCK, in his official capacity as District Attorney for Cullman County; JESSICA VENTIERE, in her official capacity as District Attorney for Lee County; TOM ANDERSON, in his official capacity as District Attorney for the 12th Judicial Circuit; and DANNY CARR, in his official capacity as District Attorney for Jefferson County.

Defendants.

Civil Action No.
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DECLARATION OF KATHY NOE, IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER & PRELIMINARY INJUNCTION

I, Kathy Noe,[1] hereby declare as follows:

1. My son, Christopher Noe, and I are plaintiffs in this action. We are citizens of Alabama and reside in Lee County, Alabama.

2. Christopher is a seventeen-year-old transgender boy. He is very passionate about music. He loves listening to all genres of music and plays the trumpet.

3. Christopher and I have resided in Lee County since we moved to Alabama just before Christopher's fourth birthday. We moved to Alabama when my now-former husband was stationed at Fort Benning, Georgia. It is common for families stationed at Fort Benning to live in Phenix City, Alabama, like we do. I also am former active-duty military. Christopher's father is still active-duty military and is currently stationed abroad.

4. Although Christopher was born on a military base in Oklahoma, Alabama is the only home he has known. He has gone to school in Alabama since kindergarten and still has friends he has known since kindergarten.

5. Although Christopher was assigned female at birth, I always knew he was not a typical girl. When Christopher was two and three years old, he had long,

[1] Because of concerns about criminal liability and my child's privacy and safety, I am seeking to proceed in this case under a pseudonym. *See Motion to Proceed Pseudonymously*, filed concurrently herewith. In addition, contemporaneous with signing this declaration, I have signed with my legal name a separate copy of this declaration. My attorneys have a copy of that separate declaration.

pretty hair, which I would put bows in and do in other traditionally girl hairstyles. He always hated it and pulled the bows out. When he was four years old, he asked to cut it short, and I agreed. Christopher loved his new, short haircut immediately.

6. When Christopher was in day care before he was old enough for school, he never played dress up with the other girls. He always wanted to wear pants and shorts. When his kindergarten tried to force Christopher to wear a skirt for their graduation ceremony, Christopher refused, and I fought the school and won the right for him to wear pants. The same thing happened in sixth grade, but this time, when the school refused to let him wear pants instead of a dress for the graduation ceremony, Christopher chose not to attend the ceremony rather than wear a dress.

7. As Christopher got older, he kept wanting his hair cut even shorter, to the point where his hair was shorter than his friends who were assigned male at birth. He also gravitated towards blues and darker colors.

8. When Christopher was around thirteen or fourteen and in his first romantic relationship, he realized that he felt more masculine than his boyfriend and identified more as a boy than a girl. That is when he told me he was transgender. Partly because it did not surprise me, I was immediately supportive.

9. After Christopher came out to me, I put him in counseling so he could talk about it with someone who had experience with transgender children and make sure he was doing what he thought was best for him.

10. About a year later, when Christopher was fifteen, he told his father he is transgender. Christopher's father needed some time to accept that Christopher is transgender, which really hurt Christopher. His father's initial hesitance also delayed Christopher starting hormone replacement therapy because it was important to me to have his father's approval first. Christopher's father ultimately came to accept Christopher's gender identity, which was a relief to Christopher and enabled him to start hormone replacement therapy. When Christopher's father came to support him at the Columbus, Georgia pride parade, Christopher was overjoyed.

11. When Christopher first came out as transgender, he continued to use his birth name, which is unisex. It was also at that time that he started using "he/him" pronouns. Recently, he expressed an interest in being referred to as Christopher instead. All his teachers at school began calling him Christopher and using "he/him" pronouns. Christopher also hopes to legally change his name, but it is difficult to do so while his father is stationed abroad.

12. Despite his social transition, when Christopher started going through female puberty it was a very hard time for both of us. He started his period at age nine, which immediately caused him extreme distress and anxiety. Christopher has never accepted the physical changes that came with female puberty and is particularly distressed by his breasts. Despite having naturally small breasts, Christopher wore a binder for nearly three years. He now prefers TransTape, which

he wears almost daily. He prefers the TransTape because it is more comfortable and looks more like skin than a bra. With the TransTape, he feels more like who he really is.

13. Christopher knows he is different because he is transgender, but counseling and seeing his family and his peers accept him has helped. His family—including me, his father, his aunt, and his siblings—and other longtime family friends have strived to support him. It was hard for Christopher when one of his longtime best friends rejected his transition, but he has many other supportive friends, and he strongly stands up to anyone who bullies him or other kids.

14. Christopher's counselor first recommended him for hormone therapy when he was sixteen. I discussed it several times with Christopher and his counselor, and we decided to pursue hormone treatment for him when he was seventeen. After being provided with a letter of recommendation from his counselor, Christopher's pediatrician referred him to an endocrinologist in November 2021. I took Christopher to his initial visit with the endocrinologist in February 2022. The endocrinologist reviewed Christopher's medical history, the recommendation of Christopher's counselor, and Christopher's lab results. He also asked how long Christopher had been seeing a counselor and how often and asked Christopher to see a psychologist as well, which he did, before he started hormone treatment.

15. Christopher received his first testosterone injection in March 2022, and

since then I have given him his injections at home every other week. His current prescription is valid until June, at which time we will have to go back to the endocrinologist for a follow up appointment, more lab testing, and a new prescription.

16. Christopher's care team includes his pediatrician, endocrinologist, mental health counselor, and psychiatrist. I consult with all of them on his care. Because we live in such a small town, so close to the Alabama–Georgia state line, all Christopher's doctors are in Columbus, Georgia. Both his endocrinologist and his psychiatrist have offices in both Georgia and Alabama, but we go to the Columbus, Georgia locations because they are closer. I fill his testosterone prescription at a pharmacy in Alabama.

17. Even though it has only been a short time since starting hormones, Christopher is already significantly and noticeably happier. He is bubbly, more outgoing, and more confident in himself. I have noticed it myself and have spoken about it with Christopher's counselor, who also has noticed these positive changes. Christopher's co-workers at the local pizza place have also noticed that Christopher is more excited to go to work and be around other people. He loves showing off his new facial hair and deeper voice.

18. Although we travel to Georgia for Christopher's care, because we live in Alabama, I am afraid of what would happen to Christopher if there were an

interference or disruption in his counseling or hormone schedule because of this law. I also fear criminal prosecution for helping my son get the care he needs.

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

Executed this 19th day of April, 2022.

Kathy Noe

EXHIBIT 9

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER; BRIANNA BOE, individually and on behalf of her minor son, MICHAEL BOE; JAMES ZOE, individually and on behalf of his minor son, ZACHARY ZOE; MEGAN POE, individually and on behalf of her minor daughter, ALLISON POE; KATHY NOE, individually and on behalf of her minor son, CHRISTOPHER NOE; JANE MOE, Ph.D.; and RACHEL KOE, M.D.

Plaintiffs,

v.

KAY IVEY, in her official capacity as Governor of the State of Alabama; STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama; DARYL D. BAILEY, in his official capacity as District Attorney for Montgomery County; C. WILSON BAYLOCK, in his official capacity as District Attorney for Cullman County; JESSICA VENTIERE, in her official capacity as District Attorney for Lee County; TOM ANDERSON, in his official capacity as District Attorney for the 12th Judicial Circuit; and DANNY CARR, in his official capacity as District Attorney for Jefferson County.

Defendants.

Civil Action No.
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DECLARATION OF JANE MOE, PhD, IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER & PRELIMINARY INJUNCTION

I, Jane Moe,[1] declare as follows:

1. I am a licensed clinical psychologist and have been practicing in Alabama for twenty years. I am licensed to practice by the State of Alabama and I work and reside in Jefferson County, Alabama.

2. I obtained my PhD in clinical child psychology with a specialization in child development from a major university in Alabama. After completing my post-doctoral work and clinical intern hours, I received my license to practice in Alabama.

3. Since I started my practice twenty years ago, I have worked exclusively with patients under the age of 24. Over that time, I have treated patients with a variety of mental health issues ranging from anxiety and depression to attention deficit hyperactivity disorder or "ADHD."

4. I currently work in a hospital setting within the University of Alabama at Birmingham (UAB) system providing direct mental health care to children and adolescents as well as training other medical providers to work with young patients. For the past two years, I have dedicated part of my practice to working with transgender young people. During that time, I have treated approximately forty transgender young people, ranging in age from five to nineteen.

[1] Because of concerns about criminal liability and my privacy and safety, I am seeking to proceed in this case under a pseudonym. See Motion to Proceed Pseudonymously, filed concurrently herewith. In addition, contemporaneous with signing this declaration, I have signed with my legal name a separate copy of this declaration. My attorneys have a copy of that separate declaration.

5. My work with transgender patients is guided by the well-established standard of care developed by the World Professional Association for Transgender Health (WPATH) and a comprehensive informed-consent protocol.

6. When I start seeing a transgender patient who presents for a mental health assessment, I make clear that the assessment is a process that engages both the patient and their parents. The process requires a minimum of three to four visits, which typically take place over the course of two to three months, depending on the needs of the patient and their family. It is not uncommon for the assessment process to require more visits and take place over a longer period of time.

7. The assessment begins with gathering background information on the patient through questionnaires, rating scales, and talking with the patient and their parents. Through those methods I build a profile of the patient: their level of adjustment and overall functioning, available coping mechanisms, and an understanding of their strengths and weaknesses.

8. As the assessment proceeds, I continue to gather information from multiple sources, including the parents, that will help me determine whether the patient meets the diagnostic criteria for gender dysphoria as outlined in the Diagnostic and Statistical Manual of Mental Disorders ("DSM-5").

9. As part of the assessment, consistent with the informed-consent protocol, I review with the patient and the patient's parents the risks, benefits, and

ranges of medical treatment available and appropriate for treating any particular patient's condition. These discussions often happen over more than one session. Based on the needs of the patient and the patient's family, I may have separate meetings with the patient and parent(s), which gives each the opportunity to ask questions or talk about issues they may not initially feel comfortable discussing in front of the other.

10. I also encourage families to seek out other services that they may find helpful, such as talking with a religious leader, either in the hospital or the community.

11. Once I have completed the informed-consent protocol and am confident that the patient and their parents understand the risk, benefits, and range of medical treatments for gender dysphoria, I write a letter to the patient's doctor detailing the results of my assessment. In addition to the diagnosis, I discuss the patient's overall mental health and functioning as well as recommendations for continued mental health care, as needed. Although my letters detail a patient's readiness from a mental health perspective, I always recommend that the patient's medical provider undertake a further assessment of the patient before initiating any medical treatment.

12. Given that I work in a hospital setting, it is not uncommon for me to see patients again after they have already begun medical treatment for their gender dysphoria. During those sessions, we often talk about how their treatment is

progressing and the effects it is having on their mental health. In those discussions, we often return to our prior conversations that we had in connection with the informed-consent protocol.

13. I understand that Governor Ivey signed the Vulnerable Child Compassion and Protection Act (the "Act"). My understanding is that the Act expressly prohibits anyone from doing or saying anything that could cause a transgender young person, under the age 19 in Alabama to undergo medical treatment for gender dysphoria. I further understand that violating the Act exposes Alabama healthcare providers and others to criminal prosecution, which could result in me or others being sentenced to prison or a fine. Effectively, the Act prevents transgender young people in Alabama from obtaining medically necessary, safe, effective, and established treatments for their gender dysphoria.

14. For me, the Act means that I would have to abandon my professional and ethical obligations when treating transgender patients or risk criminal penalty for providing mental health care consistent with the prevailing standards of care. I also will be prevented from educating my patients about treatment options for gender dysphoria or referring my patients to medical providers for further evaluation and possibly prescriptions for this essential medical care. I cannot imagine doing that and, as a result, I am very afraid that I will be subject to criminal prosecution and face criminal penalties under the Act.

15. I also am deeply concerned about the effects this law will have on my patients' mental health. Before SB 184 was debated—let alone signed into law—my patients were regularly bullied and harassed in their schools and communities. Because of the dangerous message the Act sends to Alabamians about transgender young people, many of my patients are bracing for an increase in bullying and harassment from those who would feel emboldened by the Act.

16. Receiving medical treatment for gender dysphoria has also significantly improved the mental health and wellbeing of all the patients I have seen. If healthcare providers were required to comply with the Act, it would force transgender young people to put their health-related goals on hold. Their mental health would deteriorate and impair their ability to function in their day-to-day lives. That decline in mental health will cause a cascade of negative health outcomes, including exacerbating co-occurring mental health issues, increased reliance on maladaptive coping mechanisms (*e.g.* cutting, substance abuse), and suicidality. In fact, in the days following the signing of the Act, I had to work with two patients to develop safety plans to prevent them from attempting suicide, a risk that is well-documented and disproportionately affects transgender young people. Talking with them, I could see that the hope they had for the future had been replaced with distress, anxiety and sadness.

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

Executed this 19 th day of April, 2022.

Jane Moe, PhD

Dr. Jane Moe, PhD

EXHIBIT 10

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER; BRIANNA BOE, individually and on behalf of her minor son, MICHAEL BOE; JAMES ZOE, individually and on behalf of his minor son, ZACHARY ZOE; MEGAN POE, individually and on behalf of her minor daughter, ALLISON POE; KATHY NOE, individually and on behalf of her minor son, CHRISTOPHER NOE; JANE MOE, Ph.D.; and RACHEL KOE, M.D.

Plaintiffs,

v.

KAY IVEY, in her official capacity as Governor of the State of Alabama; STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama; DARYL D. BAILEY, in his official capacity as District Attorney for Montgomery County; C. WILSON BAYLOCK, in his official capacity as District Attorney for Cullman County; JESSICA VENTIERE, in her official capacity as District Attorney for Lee County; TOM ANDERSON, in his official capacity as District Attorney for the 12th Judicial Circuit; and DANNY CARR, in his official capacity as District Attorney for Jefferson County.

Defendants.

Civil Action No.
_____

DECLARATION OF RACHEL KOE, MD, IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER & PRELIMINARY INJUNCTION

I, Rachel Koe,[1] declare as follows:

1. I am a physician licensed to practice by the State of Alabama. I work in southeast Alabama.

2. I attended medical school in Alabama and, since completing my pediatrics residency, have provided care to patients in rural southeast Alabama. I have been practicing for approximately ten years.

3. As a board-certified pediatrician, I treat patients from birth to nineteen years of age. Because I provide primary medical care, my patients present with a wide range of physical and mental health conditions. That also means that I have a wide network of medical and mental health providers that I rely on to refer patients who require subspecialty care. I am very careful with my referrals, ensuring that I am referring my patients to providers who offer quality care and follow evidence-based medicine.

4. About eight years ago, I started treating my first transgender patient. I had learned about gender dysphoria during my medical residency, but had never treated a transgender patient. When the patient first came under my care, he was seeing a therapist, a psychiatrist, and pastoral counselor, but his health and wellbeing

[1] Because of concerns about criminal liability and my privacy and safety, I am seeking to proceed in this case under a pseudonym. *See Motion to Proceed Pseudonymously*, filed concurrently herewith. In addition, contemporaneous with signing this declaration, I have signed with my legal name a separate copy of this declaration. My attorneys have a copy of that separate declaration.

were not improving despite this care. His mother knew that her son, who had been assigned female at birth, was struggling with gender dysphoria, but the only answer she had been given to that point was more psychiatric medication. She came to me scared that her son's declining mental health was placing him at serious risk for self-harm or even suicide.

5. Because of my involvement in pediatrics community in Alabama, I had heard of the gender clinic at UAB and referred this patient to the clinic. The referral was life changing for my patient. After about six months, he started puberty-blocking medications and approximately eighteen months later began taking testosterone. Over that time, my patient became a totally different child. He blossomed in ways that neither I nor his mother could have anticipated.

6. Due to the distance between my patient's home and the gender clinic in Birmingham, he would come to my office for regular blood work. I would always review the test results to make sure there wasn't something urgently wrong and would then pass the results along to his medical providers at the UAB gender clinic. Once my patient started testosterone, he did not feel comfortable self-administering the medication so he came to my office every other week to have my medical staff give him his medication.

7. This patient has graduated from my practice, but his mother keeps me updated on his life. According to his mother, he continues to thrive as a healthy and well-adjusted adult.

8. After seeing the difference in my patient once he received care at the gender clinic, I started to learn more about medical treatments for gender dysphoria so that I would be better able to answer questions posed to me by future patients and their parents. As part of my self-study, I familiarized myself with the medical literature including publications by the World Professional Association for Transgender Health and the Endocrine Society detailing the standards of care for medical treatment for gender dysphoria.

9. Since then, I have treated four more transgender patients. When those patients first came to see me, most had just started expressing that they were transgender. Given that, I referred them to local mental health providers for support. Once the patient was diagnosed with gender dysphoria and reached an age where medical treatment may be appropriate, I referred them to the gender clinic for further evaluation and specialty care. As with my first patient eight years ago, these patients would come to me for regular blood tests and lab work, the results of which would be sent to the UAB gender clinic so their medical providers could monitor their progress.

10. Unfortunately, not all those patients were fortunate enough to have supportive parents to take them for treatment at the UAB gender clinic, but those who did were able to lead the happy and healthy lives that every parent wants for their child. One of those patients is still under my care to this day.

11. As a pediatrician, I see my purpose as increasing access to quality, evidence-based care for children throughout Alabama. If allowed to go into effect, the Vulnerable Child Compassion and Protection Act (the "Act") would do the opposite. My transgender patient, and every other transgender young person across Alabama, would be denied evidence-based medical treatment for gender dysphoria. As a medical provider, this situation is very concerning to me. I am certain that my transgender patient's mental health will suffer significantly if she is denied ongoing medical treatment for her gender dysphoria. If I were to comply with the Act, I would be limited to referring her to counseling and a psychiatrist. Doing so would be a violation of my professional and ethical duties as a physician for two reasons: (1) talk therapy and psychiatric medication alone will not be effective in treating her gender dysphoria; and (2) I would be refusing to provide proven effective treatments, namely puberty-blocking medications and estrogen. That course of treatment is consistent with the standards of care and is well-supported in the medical literature by data published in reputable and peer-reviewed medical journals.

12. This Act also would criminalize me for making appropriate referrals to providers, such as the UAB gender clinic, who can offer the specialized care that transgender young people need. The Act would prevent me from answering parent questions and educating them about the literature underpinning the current standards of care. Without primary care providers who can share that critical information with transgender youth and their parents and connect them with healthcare providers who treat gender dysphoria, families raising transgender children will experience even greater isolation and barriers to medical providers with the necessary expertise to offer quality medical care. Even my support staff are concerned that the broad language used in the Act could result in them violating the Act simply by helping to provide competent quality care.

13. The Act places me in an impossible situation on multiple fronts. If I comply with the Act to avoid criminal penalties, I am abandoning my current transgender patient by not providing medical care consistent with the accepted standard of care. Further, as a medical provider who accepts Alabama Medicaid, and thus receives federal funds, complying with the act would require me to discriminate against transgender patients, jeopardizing all of my patients' access to care by violating federal antidiscrimination laws.

14. This Act also sets a dangerous precedent for interfering with the sanctity of the doctor-patient relationship. If the Alabama legislature can criminalize

evidence-based medical treatment for gender dysphoria, the Act may have a chilling effect on the treatment of many other conditions where public opinion may not align with medical treatments grounded in evidence-based standards of care.

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

Executed this 19 th day of April, 2022.

Rachel Koe, MD

Dr. Rachel Koe, MD