

No. 22-11707

**UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT**

◆

PAUL A. EKNES-TUCKER, et al.,
Plaintiffs-Appellees,

&

UNITED STATES OF AMERICA
Intervenor-Plaintiff-Appellee,

v.

GOVERNOR OF THE STATE OF ALABAMA, et al.,
Defendants-Appellants.

◆

On Appeal from the United States District Court
for the Middle District of Alabama
Case No. 2:22-cv-184-LCB

APPELLANTS' APPENDIX VOLUME I OF XIII

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Alabama Middle District (Montgomery)
CIVIL DOCKET FOR CASE #: 2:22-cv-00184-LCB-SRW

Eknes-Tucker et al v. Marshall et al
Assigned to: Honorable Judge Liles C. Burke
Referred to: Honorable Judge Susan Russ Walker
Case in other court: 22-11707-JJ
Cause: 42:1983 Civil Rights Act

Date Filed: 04/19/2022
Jury Demand: None
Nature of Suit: 950 Constitutional - State
Statute
Jurisdiction: Federal Question

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Amicus

The Endocrine Society

represented by **Barry Alan Ragsdale**
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**National Association of Pediatric Nurse
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Society of Pediatric Nurses

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**World Professional Association for
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American Pediatric Society

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*LEAD ATTORNEY**ATTORNEY TO BE NOTICED*

Date Filed	#	Docket Text
04/19/2022	<u>1</u>	COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF against Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Kay Ivey, Steve Marshall, Jessica Ventiere (Filing fee \$ 402.00 receipt number 4602066590.), filed by Kathy Noe, Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Megan Poe, James Zoe, Jane Moe. (Attachments: # <u>1</u> Civil Cover Sheet, # <u>2</u> Receipt) (wcl,) (Entered: 04/20/2022)
04/20/2022	<u>2</u>	Summons Issued as to Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Kay Ivey, Steve Marshall, Jessica Ventiere and returned to counsel for personal service by process server. (wcl,) (Entered: 04/20/2022)
04/20/2022	<u>3</u>	ORDER: The Honorable Liles C. Burke, United States District Judge for the Northern District of Alabama, was previously assigned two cases substantially similar to the above-captioned case, both of which were voluntarily dismissed on April 15, 2022. By order of the Chief Judge of the United States Court of Appeals for the Eleventh Circuit, all United States District Judges in the State of Alabama may preside over cases in any of the State's three federal judicial districts. In accordance with that order, and by the authority of the Court to manage the district court docket, promote the orderly and expeditious disposition of cases, and reassign a case to a judge who presided over a prior-related case, this case is REASSIGNED to Judge Burke. Judge Burke shall sit by designation and preside over this case in

		the United States District Court for the Middle District of Alabama. Signed by Honorable Judge R. Austin Huffaker, Jr on 4/20/2022. (wcl,) (Entered: 04/20/2022)
04/20/2022	4	Case Reassigned to Honorable Judge Liles C. Burke as presiding judge; Honorable Judge R. Austin Huffaker, Jr no longer assigned to the case. (wcl,) (Entered: 04/20/2022)
04/20/2022	5	ORDER setting Status Conference for Friday, 4/22/2022, at 10:00 AM CDT in Courtroom 2F before Honorable Judge Liles C. Burke; Local counsel for Plaintiffs shall electronically serve a copy of this order on all non-local counsel for Plaintiffs and on all counsel for Defendants. Signed by Honorable Judge Liles C. Burke on 4/20/2022. (furn: calendar, dh) (wcl,) (Entered: 04/20/2022)
04/20/2022	6	MOTION for Leave to File (<i>Motion for Leave to Proceed Pseudonymously</i>) by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) (Entered: 04/20/2022)
04/21/2022	7	MOTION for Preliminary Injunction , MOTION for Temporary Restraining Order by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Attachments: # 1 Text of Proposed Order - Temporary Restraining Order, # 2 Text of Proposed Order - Preliminary Injunction)(Eagan, Melody) (Entered: 04/21/2022)
04/21/2022	8	BRIEF/MEMORANDUM in Support re 7 MOTION for Preliminary Injunction MOTION for Temporary Restraining Order filed by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Attachments: # 1 Exhibit 1 - Hawkins Declaration, # 2 Exhibit 2 - Ladinsky Declaration, # 3 Exhibit 3 - Rosenthal Declaration, # 4 Exhibit 4 - Eknes-Tucker Declaration, # 5 Exhibit 5 - Boe Declaration, # 6 Exhibit 6 - Zoe Declaration, # 7 Exhibit 7 - Poe Declaration, # 8 Exhibit 8 - Noe Declaration, # 9 Exhibit 9 - Moe Declaration, # 10 Exhibit 10 - Koe Declaration)(Eagan, Melody) (Entered: 04/21/2022)
04/21/2022	9	Alias Summons issued as to Daryl D. Bailey and returned to Counsel for service via Process Server. (cwl,) (Entered: 04/21/2022)
04/21/2022	10	NOTICE of Appearance by Edmund Gerard LaCour, Jr on behalf of Kay Ivey, Steve Marshall (LaCour, Edmund) (Entered: 04/21/2022)
04/21/2022	11	NOTICE of Appearance by Thomas Alexander Wilson on behalf of Kay Ivey, Steve Marshall (Wilson, Thomas) (Entered: 04/21/2022)
04/21/2022	12	NOTICE of Appearance by Alexander Barrett Bowdre on behalf of Kay Ivey, Steve Marshall (Bowdre, Alexander) (Entered: 04/21/2022)
04/21/2022	13	SUMMONS Returned Executed by Kathy Noe, Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Megan Poe, James Zoe, Jane Moe. Danny Carr served on 4/21/2022, answer due 5/12/2022. (Eagan, Melody) (Entered: 04/21/2022)
04/21/2022	14	NOTICE of Appearance by Benjamin Matthew Seiss on behalf of Kay Ivey, Steve Marshall (Seiss, Benjamin) (Main Document 14 replaced on 4/21/2022 to attach the correct main PDF document to correct the style of the case) (cwl,). (Entered: 04/21/2022)
04/21/2022	15	NOTICE of Correction re 14 Notice of Appearance, to attach the correct main PDF document to correct the style of the case. (Attachments: # 1 Correct Main doc entry 14) (cwl,) (Entered: 04/21/2022)
04/21/2022	16	Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement sent to Kathy Noe, Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Megan Poe, James Zoe, Jane Moe. Corporate Disclosures due by 5/2/2022. (Attachments: # 1 Conflict Statement Standing Order & Sample Format)(cwl,) (Entered: 04/21/2022)

04/21/2022	<u>17</u>	Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement sent to Steve Marshall & Kay Ivey. Corporate Disclosures due by 5/2/2022. (Attachments: # <u>1</u> Conflict Statement Standing Order & Sample Format)(cwl,) (Entered: 04/21/2022)
04/21/2022	<u>18</u>	NOTICE of Appearance by James William Davis on behalf of All Defendants (Davis, James) (Entered: 04/21/2022)
04/21/2022	<u>19</u>	Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement sent to Danny Carr, Tom Anderson, Jessica Ventiere, C. Wilson Baylock & Daryl D. Bailey. Corporate Disclosures due by 5/2/2022. (Attachments: # <u>1</u> Conflict Statement Standing Order & Sample Format)(cwl,) (Entered: 04/21/2022)
04/21/2022	<u>20</u>	ANSWER to <u>1</u> Complaint, by Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Steve Marshall, Jessica Ventiere.(Davis, James) (Entered: 04/21/2022)
04/21/2022	<u>21</u>	Corporate/Conflict Disclosure Statement re <u>19</u> Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement by Tom Anderson. (Davis, James) Modified on 4/22/2022 to add link to def notice (cwl,). (Entered: 04/21/2022)
04/21/2022	<u>22</u>	Corporate/Conflict Disclosure Statement re <u>19</u> Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement by Daryl D. Bailey. (Davis, James) Modified on 4/22/2022 to add link to def notice (cwl,). (Entered: 04/21/2022)
04/21/2022	<u>23</u>	Corporate/Conflict Disclosure Statement re <u>19</u> Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement by C. Wilson Baylock. (Davis, James) Modified on 4/22/2022 to add link to def notice (cwl,). (Entered: 04/21/2022)
04/21/2022	<u>24</u>	Corporate/Conflict Disclosure Statement re <u>19</u> Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement by Danny Carr. (Davis, James) Modified on 4/22/2022 to add link to def notice (cwl,). (Entered: 04/21/2022)
04/21/2022	<u>25</u>	Corporate/Conflict Disclosure Statement re <u>17</u> Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement by Kay Ivey. (Davis, James) Modified on 4/22/2022 to add link to def notice (cwl,). (Entered: 04/21/2022)
04/21/2022	<u>26</u>	Corporate/Conflict Disclosure Statement re <u>17</u> Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement by Steve Marshall. (Davis, James) Modified on 4/22/2022 to add link to def notice (cwl,). (Entered: 04/21/2022)
04/21/2022	<u>27</u>	Corporate/Conflict Disclosure Statement re <u>19</u> Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement by Jessica Ventiere. (Davis, James) Modified on 4/22/2022 to add link to def notice (cwl,). (Entered: 04/21/2022)
04/21/2022	<u>28</u>	SUMMONS Returned Executed by Kathy Noe, Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Megan Poe, James Zoe, Jane Moe. Daryl D. Bailey served on 4/21/2022, answer due 5/12/2022. (Eagan, Melody) (Entered: 04/21/2022)
04/21/2022	<u>29</u>	SUMMONS Returned Executed by Kathy Noe, Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Megan Poe, James Zoe, Jane Moe. Tom Anderson served on 4/21/2022, answer due 5/12/2022. (Eagan, Melody) (Entered: 04/21/2022)
04/21/2022	<u>30</u>	SUMMONS Returned Executed by Kathy Noe, Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Megan Poe, James Zoe, Jane Moe. Jessica Ventiere served on 4/21/2022, answer due 5/12/2022. (Eagan, Melody) (Entered: 04/21/2022)
04/21/2022	<u>31</u>	SUMMONS Returned Executed by Kathy Noe, Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Megan Poe, James Zoe, Jane Moe. Steve Marshall served on 4/21/2022, answer due 5/12/2022. (Eagan, Melody) (Entered: 04/21/2022)
04/21/2022	<u>32</u>	SUMMONS Returned Executed by Kathy Noe, Brianna Boe, Paul A. Eknes-Tucker,

		Rachel Koe, Megan Poe, James Zoe, Jane Moe. Kay Ivey served on 4/21/2022, answer due 5/12/2022. (Eagan, Melody) (Entered: 04/21/2022)
04/21/2022		***PURSUANT TO THE 20 ANSWER - Attorney Edmund Gerard LaCour, Jr, Alexander Barrett Bowdre, Benjamin Matthew Seiss for Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Jessica Ventiere added. (NO pdf attached to this entry) (cwl,) (Entered: 04/22/2022)
04/22/2022	33	Minute Entry for proceedings held before Honorable Judge Liles C. Burke: Status Conference held on 4/22/2022 (PDF available for court use only). (Court Reporter Christina Decker w/ND AL.) (dh) (Entered: 04/22/2022)
04/22/2022	34	ORDER Setting Hearing on Motion: Evidentiary Hearing on Plfs' 7 motion for a temporary restraining order and/or a preliminary injunction is set for Thursday, 5/5/2022, at 9:00 a.m. CDT in Courtroom 2F before Honorable Judge Liles C. Burke; The hearing is scheduled to last no longer than two days with the time allotted strictly as represented by the parties during today's status conference; Forty-eight hours before the hearing begins, the parties shall file their proposed exhibits and a list of expected witnesses; On or before 4/27/2022, Dfts shall file a response to Plfs' 6 motion to proceed pseudonymously; Plfs' reply is due thirty-six hours after Dfts file their response; On or before 5/2/2022, Dfts shall file a response to Plfs' 7 motion for a temporary restraining order and/or a preliminary injunction; Plfs' reply is due thirty-six hours after Dfts file their response. Signed by Honorable Judge Liles C. Burke on 4/22/2022. (furn: calendar, dh) (wcl,) (Entered: 04/22/2022)
04/25/2022	35	Corporate/Conflict Disclosure Statement re 16 Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement by Paul A. Eknes-Tucker. (Eagan, Melody) Modified on 4/26/2022 to add link (cwl,). (Main Document 35 replaced on 4/26/2022 to lock down fillable PDF) (cwl,). (Entered: 04/25/2022)
04/25/2022	36	Corporate/Conflict Disclosure Statement re 16 Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement by Rachel Koe. (Eagan, Melody) Modified on 4/26/2022 to add link (cwl,). (Main Document 36 replaced on 4/26/2022 to lock down fillable PDF) (cwl,). (Entered: 04/25/2022)
04/25/2022	37	Corporate/Conflict Disclosure Statement re 16 Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement by Jane Moe. (Eagan, Melody) Modified on 4/26/2022 to add link (cwl,). (Main Document 37 replaced on 4/26/2022 to lock down fillable PDF) (cwl,). (Entered: 04/25/2022)
04/25/2022	38	Corporate/Conflict Disclosure Statement re 16 Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement by Kathy Noe. (Eagan, Melody) Modified on 4/26/2022 to add link (cwl,). (Main Document 38 replaced on 4/26/2022 to lock down fillable PDF) (cwl,). (Entered: 04/25/2022)
04/25/2022	39	Corporate/Conflict Disclosure Statement re 16 Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement by Megan Poe. (Eagan, Melody) Modified on 4/26/2022 to add link (cwl,). (Main Document 39 replaced on 4/26/2022 to lock down fillable PDF) (cwl,). (Entered: 04/25/2022)
04/25/2022	40	Corporate/Conflict Disclosure Statement re 16 Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement by Brianna Boe. (Eagan, Melody) Modified on 4/26/2022 to add link (cwl,). (Main Document 40 replaced on 4/26/2022 to lock down fillable PDF) (cwl,). (Entered: 04/25/2022)
04/25/2022	41	Corporate/Conflict Disclosure Statement re 16 Notice of Deficiency requiring filing of Corporate Disclosure/Conflict Statement by James Zoe. (Eagan, Melody) Modified on

		4/26/2022 to add link (cwl,). (Main Document 44 replaced on 4/26/2022 to lock down fillable PDF) (cwl,). (Entered: 04/25/2022)
04/26/2022	42	Motion for Michael B. Shortnacy to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3210502.) by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) Modified on 4/26/2022 to add attorney's name to text & clarify that exhibit A is contained within the main PDF document (cwl,). (Entered: 04/26/2022)
04/26/2022	43	Motion for Brent P. Ray to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3210505.) by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) Modified on 4/26/2022 to add attorney's name to text & clarify that exhibit A is contained within the main PDF (cwl,). (Entered: 04/26/2022)
04/26/2022	44	Motion for Abigail Hoverman Terry to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3210507.) by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) Modified on 4/26/2022 to add attorney's name to text & clarify that exhibit A is contained within the main PDF (cwl,). (Entered: 04/26/2022)
04/26/2022	45	Motion for Misty L. Peterson to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3210508.) by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) Modified on 4/26/2022 to add attorney's name to text & clarify exhibit A is contained within the main PDF (cwl,). (Entered: 04/26/2022)
04/26/2022	46	Motion for Gilbert Olusegun Oladeinbo to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number CALMDC-3210509.) by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) Modified on 4/26/2022 to add attorney's name to text & clarify exhibit A is contained within the main PDF (cwl,). (Entered: 04/26/2022)
04/26/2022	47	Motion for Adam Reinke to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3210527.) by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) Modified on 4/26/2022 to add attorney's name to text & clarify exhibit A is contain within the main PDF (cwl,). (Entered: 04/26/2022)
04/26/2022	48	Motion for Asaf Orr to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3210529.) by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) Modified on 4/26/2022 to add attorney's name to text & clarify exhibit A is contained within the main PDF (cwl,). (Entered: 04/26/2022)
04/26/2022	49	Motion for Jessica Lynn Stone to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3210531.) by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) Modified on 4/26/2022 to add attorney's name to text & clarify exhibit A is contained within the main PDF (cwl,). (Entered: 04/26/2022)
04/26/2022	50	Motion for Jennifer L. Levi to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3210536.) by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) Modified on 4/26/2022 to add attorney's name to text & clarify exhibit A is contained within the main PDF (cwl,). (Entered: 04/26/2022)
04/26/2022	51	Motion for Cynthia Cheng-Wun Weaver to Appear Pro Hac Vice (Filing fee \$ 75.00

		receipt number AALMDC-3210537.) by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) Modified on 4/26/2022 to add attorney's name to text & clarify exhibit A is contained within the main PDF(cwl,). (Entered: 04/26/2022)
04/26/2022	52	Motion for Scott D. McCoy to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3210538.) by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) Modified on 4/26/2022 to add attorney's name to text & clarify exhibit A is contained within the main PDF (cwl,). (Entered: 04/26/2022)
04/26/2022	53	Motion for Sarah Warbelow to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3210892.) by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) Modified on 4/27/2022 to add attorney's name to text & to clarify exhibit A is contained within the main PDF (cwl,). (Entered: 04/26/2022)
04/27/2022	54	RESPONSE <i>in Partial Opposition</i> to Motion re 6 MOTION for Leave to File (<i>Motion for Leave to Proceed Pseudonymously</i>) filed by Kay Ivey, Steve Marshall, Danny Carr, Tom Anderson, Jessica Ventiere, C. Wilson Baylock, Daryl D. Bailey, . (LaCour, Edmund) Modified on 4/27/2022 to clarify text (cwl,). Modified on 4/27/2022 to add additional defs as filers (cwl,). (Entered: 04/27/2022)
04/27/2022	55	NOTICE of Appearance by Thomas Alexander Wilson on behalf of Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Jessica Ventiere (Wilson, Thomas) (Entered: 04/27/2022)
04/28/2022	56	Motion for Christopher E. Mills to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3212297.) by Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Kay Ivey, Steve Marshall, Jessica Ventiere. (Attachments: # 1 Exhibit Certificate of Good Standing)(LaCour, Edmund) Modified on 4/28/2022 to add attorney's name to text (cwl,). (Entered: 04/28/2022)
04/28/2022		***PURSUANT TO THE 56 MOTION - Attorney Christopher Ernest Mills for Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Kay Ivey, Steve Marshall, Jessica Ventiere added. (NO pdf attached to this entry) (cwl,) (Entered: 04/28/2022)
04/28/2022	57	REPLY to Response to Motion re 6 MOTION for Leave to File (<i>Motion for Leave to Proceed Pseudonymously</i>) filed by Brianna Boe, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe, Paul A. Eknes-Tucker. (Attachments: # 1 Exhibit A - Supplemental Declaration of Rachel Koe, MD)(Eagan, Melody) Modified on 4/29/2022 to add additional PLF as filer (cwl,). (Entered: 04/28/2022)
04/29/2022	58	MOTION to Intervene by United States of America. (Attachments: # 1 Memorandum of Law, # 2 Exhibit Attorney Generals Certification, # 3 Exhibit Complaint in Intervention) (Cheek, Jason) (Entered: 04/29/2022)
04/29/2022	59	Corporate/Conflict Disclosure Statement by United States of America. (Cheek, Jason) (Entered: 04/29/2022)
04/29/2022	60	MOTION for Leave to File Excess Pages (<i>for Forthcoming Motion for a Temporary Restraining Order and a Preliminary Injunction</i>) by United States of America. (Cheek, Jason) (Entered: 04/29/2022)
04/29/2022	61	TEXT ORDER: If any party has opposition to either the Government's 58 motion to intervene or 60 motion for leave to file excess pages, they shall file a response no later than 5/2/2022, at 12:00 p.m. CDT. Signed by Honorable Judge Liles C. Burke on 4/29/2022. (No pdf attached to this entry) (wcl,) (Entered: 04/29/2022)

04/29/2022	62	MOTION for Preliminary Injunction, MOTION for Temporary Restraining Order by United States of America. (Attachments: # 1 Memorandum of Law, # 2 Antommara Declaration)(Cheek, Jason) (Entered: 04/29/2022)
04/29/2022		MEMORANDUM in Support re 62 MOTION for Preliminary Injunction MOTION for Temporary Restraining Order filed by United States of America. (No pdf attached to this entry - see doc 62 for pdf) (cwl,) (Entered: 05/02/2022)
04/29/2022		***PURSUANT TO THE 58 MOTION - Attorney Sandra Jean Stewart, Lane H. Woodke, Stephen D Wadsworth, Alyssa C. Lareau, Renee Williams, Kaitlin Toyama for United States of America added. (No pdf attached to this entry) (cwl,) (Entered: 05/02/2022)
04/29/2022		***PURSUANT TO THE 58 MOTION - Attorney Elizabeth Prim Formby Escalona, John Michael Powers, Coty Rae Montag for United States of America added. (No pdf attached to this entry) (cwl,) (Entered: 05/02/2022)
05/02/2022	63	RESPONSE in Partial Opposition to Motion re 60 MOTION for Leave to File Excess Pages (for Forthcoming Motion for a Temporary Restraining Order and a Preliminary Injunction), 58 MOTION to Intervene filed by Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Kay Ivey, Steve Marshall, Jessica Ventiere. (Attachments: # 1 Exhibit Harris Declaration)(LaCour, Edmund) Modified on 5/2/2022 to clarify text (cwl,). (Entered: 05/02/2022)
05/02/2022	64	RESPONSE to Motion re 58 MOTION to Intervene (PLAINTIFFS' RESPONSE TO THE UNITED STATES MOTION TO INTERVENE AND DEFENDANTS' RESPONSE filed by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) (Entered: 05/02/2022)
05/02/2022	65	REPLY to Response to Motion re 60 MOTION for Leave to File Excess Pages (for Forthcoming Motion for a Temporary Restraining Order and a Preliminary Injunction), 58 MOTION to Intervene filed by United States of America. (Cheek, Jason) (Entered: 05/02/2022)
05/02/2022	66	NOTICE of Appearance by Lane Hines Woodke on behalf of United States of America (Woodke, Lane) (Entered: 05/02/2022)
05/02/2022	67	NOTICE of Appearance by Coty Rae Montag on behalf of United States of America (Montag, Coty) (Entered: 05/02/2022)
05/02/2022	68	NOTICE of Appearance by John Michael Powers on behalf of United States of America (Powers, John) (Entered: 05/02/2022)
05/02/2022	69	NOTICE of Filing of Evidence in Opposition to Plaintiffs' Motion for Preliminary Injunction by Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Kay Ivey, Steve Marshall, Jessica Ventiere (Attachments: # 1 Exhibit 1, # 2 Exhibit 2, # 3 Exhibit 3, # 4 Exhibit 4, # 5 Exhibit 5, # 6 Exhibit 6, # 7 Exhibit 7, # 8 Exhibit 8, # 9 Exhibit 9, # 10 Exhibit 10, # 11 Exhibit 11, # 12 Exhibit 12, # 13 Exhibit 13, # 14 Exhibit 14, # 15 Exhibit 15, # 16 Exhibit 16, # 17 Exhibit 17, # 18 Exhibit 18, # 19 Exhibit 19, # 20 Exhibit 20, # 21 Exhibit 21, # 22 Exhibit 22, # 23 Exhibit 23, # 24 Exhibit 24, # 25 Exhibit 25, # 26 Exhibit 26, # 27 Exhibit 27, # 28 Exhibit 28, # 29 Exhibit 29, # 30 Exhibit 30, # 31 Exhibit 31, # 32 Exhibit 32, # 33 Exhibit 33, # 34 Exhibit 34, # 35 Exhibit 35, # 36 Exhibit 36, # 37 Exhibit 37, # 38 Exhibit 38, # 39 Exhibit 39, # 40 Exhibit 40)(Davis, James) Modified on 5/3/2022 to clarify text (cwl,). (Entered: 05/02/2022)
05/02/2022	70	Motion for Michael A. Cantrell to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3214501.) by State of Arkansas, State of Alaska, State of Arizona,

		State of Georgia, State of Indiana, State of Louisiana, State of Mississippi, State of Missouri, State of Montana, State of Nebraska, State of Oklahoma, State of South Carolina, State of Texas, State of Utah, State of West Virginia . (Wilkerson, Mark) Modified on 5/3/2022 to add attorney's name to text & clarify exhibit A is contained within the main PDF (cwl,). Modified on 5/3/2022 to add additional filers (cwl,). (Entered: 05/02/2022)
05/02/2022	71	First MOTION for Leave to File <i>Amici Brief</i> by State of Arkansas, State of Alaska, State of Arizona, State of Georgia, State of Indiana, State of Louisiana, State of Mississippi, State of Missouri, State of Montana, State of Nebraska, State of Oklahoma, State of South Carolina, State of Texas, State of Utah and State of West Virginia . (Wilkerson, Mark) Modified on 5/3/2022 to add additional filers (cwl,). (Entered: 05/02/2022)
05/02/2022	72	BRIEF/MEMORANDUM in Support re 71 First MOTION for Leave to File <i>Amici Brief</i> filed by State of Arkansas, State of Alaska, State of Arizona, State of Georgia, State of Indiana, State of Louisiana, State of Mississippi, State of Missouri, State of Montana, State of Nebraska, State of Oklahoma, State of South Carolina, State of Texas, State of Utah and State of West Virginia . (Wilkerson, Mark) Modified on 5/3/2022 to add additional filers (cwl,). (Entered: 05/02/2022)
05/02/2022	73	Corporate/Conflict Disclosure Statement by State of Arkansas, State of Alaska, State of Arizona, State of Georgia, State of Indiana, State of Louisiana, State of Mississippi, State of Missouri, State of Montana, State of Nebraska, State of Oklahoma, State of South Carolina, State of Texas, State of Utah and State of West Virginia . (Wilkerson, Mark) Modified on 5/3/2022 to remove erroneous link (cwl,). Modified on 5/3/2022 to add additional filers (cwl,). (Entered: 05/02/2022)
05/02/2022	74	RESPONSE in Opposition re 7 MOTION for Preliminary Injunction MOTION for Temporary Restraining Order filed by Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Kay Ivey, Steve Marshall, Jessica Ventiere. (LaCour, Edmund) (Entered: 05/02/2022)
05/02/2022	75	ORDER: A hearing on the United States's 58 motion to intervene is set for Wednesday, 5/4/2022, at 1:15 p.m. CDT; The hearing will occur in Courtroom 2F of the Frank M. Johnson, Jr., United States Courthouse Complex; Since the State of Alabama has no opposition to the United States's 60 motion to file excess pages, the Court will grant that motion should the Court grant the United States's motion to intervene. Signed by Honorable Judge Liles C. Burke on 5/2/2022. (Furnished: Calendar & All CRDs)(amf,) (Entered: 05/02/2022)
05/02/2022	76	ORDER: the Court ORDERS as follows: 1. Court guests, including the press and non-participants, are prohibited from possessing and using any electronic devices in Courtroom 2F during the upcoming hearings in this case; The attorneys and members of their respective staffs may possess and use electronic or photographic technology in Courtroom 2F for the sole purpose of presenting evidence; 2. Members of the press and media shall be allowed to possess cellular phones, laptop computers, and/or tablets in Courtroom 2E and the media lounge provided that these electronic devices shall be allowed: (1) for the purposes of taking notes, personal communication unrelated to the proceedings, and accessing information only; and (2) on the condition that no photographs, audio or video recording, or live broadcasting, including digitally sharing, posting, or microblogging via a social or other media site, be conducted in the courthouse; All devices shall be registered with court security upon entry into the building; All are reminded of the prohibitions regarding photographing, recording, and/or broadcasting court proceedings, as further set out in order. Signed by Honorable Judge Liles C. Burke on 5/2/2022. (amf,) (Entered: 05/02/2022)

05/02/2022		Exhibit List by Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Kay Ivey, Steve Marshall, Jessica Ventiere. (No pdf attached to this entry - see doc 69 for pdf) (cwl,) (Entered: 05/03/2022)
05/02/2022	102	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of STATUS CONFERENCE (PDF ACCESS RESTRICTED FOR 90 DAYS) held on 4/22/2022, before Judge Liles C. Burke. Court Reporter/Transcriber Christina K. Decker, Telephone number 256-506-0085. Transcript may be viewed at the court public terminal or purchased through the Court Reporter/Transcriber before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER. NOTICE OF INTENT TO REQUEST REDACTION DUE WITHIN 7 BUSINESS DAYS. Redaction Request due 5/23/2022. Redacted Transcript Deadline set for 6/2/2022. Release of Transcript Restriction set for 8/1/2022. (cwl,) (Entered: 05/12/2022)
05/03/2022	77	Witness List by Kay Ivey, Steve Marshall, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Tom Anderson, Jessica Ventiere. (Davis, James) Modified on 5/3/2022 to add additional filers left off by e-filer (cwl,). (Entered: 05/03/2022)
05/03/2022	78	Exhibit List by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe.. (Attachments: # 1 Exhibit 1 Boe, Brianna, # 2 Exhibit 2. Eknes-Ticker, Paul, # 3 Exhibit 3. Hawkins, Linda, # 4 Exhibit 4. Koe, Rachel, # 5 Exhibit 5. Koe, Rachel Supp, # 6 Exhibit 6. Ladinsky, Morissa, # 7 Exhibit 7. Ladinsky CV 11 1 21, # 8 Exhibit 8. Moe, Jane, # 9 Exhibit 9. Noe, Kathy, # 10 Exhibit 10. Poe, Megan, # 11 Exhibit 11. Rosenthal, Stephen, # 12 Exhibit 12. Zoe, James, # 13 Exhibit 13. A. Declaration, # 14 Exhibit 14. E. Guidelines, # 15 Exhibit 15. AACAP Statement, # 16 Exhibit 16. E. Society 2020 Statement, # 17 Exhibit 17. WPATH, # 18 Exhibit 18. USPATH, # 19 Exhibit 19. Yale Report, # 20 Exhibit 20. ACP, # 21 Exhibit 21. AMA, # 22 Exhibit 22. Amer Academy Peds, # 23 Exhibit 23. APA Position Statement, # 24 Exhibit 24. Endocrine Ped Statement, # 25 Exhibit 25. Trans Youth Fact Sheet, # 26 Exhibit 26. WPATH Joint Statement, # 27 Exhibit 27. Joint Statement, # 28 Exhibit 28. Statement re AL Law, # 29 Exhibit 29. TURBAN, # 30 Exhibit 30. Am Academy Peds, # 31 Exhibit 31. Ala Psych, # 32 Exhibit 32. Am Academy Peds, # 33 Exhibit 33. De VRIES, # 34 Exhibit 34. COSTA Support, # 35 Exhibit 35. DELARA, # 36 Exhibit 36. TURBAN, # 37 Exhibit 37. TURBAN, # 38 Exhibit 38. Judgment, # 39 Exhibit 39. AB v CV, # 40 Exhibit 40. Photos Under Seal, # 41 Exhibit 41. UAB Consent Form, # 42 Exhibit 42. ACHILLE, # 43 Exhibit 43. TORDOFF, # 44 Exhibit 44. Allen)(Eagan, Melody) (Attachment 40 replaced on 5/16/2022 TO ADD SEALED EXHIBIT TO THE DOCKET) (cwl,). (Entered: 05/03/2022)
05/03/2022	79	Witness List by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) (Entered: 05/03/2022)
05/03/2022	80	Exhibit List <i>and Witness List</i> by United States of America.. (Attachments: # 1 Exhibit Diagnostic & Statistical Manual of Mental Disorders, # 2 Exhibit American Academy of Pediatrics 2018 Policy Statement, # 3 Exhibit Endocrine Society Clinical Practice Guideline, # 4 Exhibit WPATH Standards of Care, # 5 Exhibit Alabama Psychological Association Statement, # 6 Exhibit American Academy of Pediatrics 2022 Statement, # 7 Exhibit Antommara Decl., # 8 Exhibit Antommara Bibliography, # 9 Exhibit Antommara Curriculum Vitae, # 10 Exhibit FDA Article, # 11 Exhibit Article: Biased Science, # 12 Exhibit ABC News Article)(Cheek, Jason) (Entered: 05/03/2022)
05/03/2022	81	<i>Supplemental</i> Exhibit List by Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Kay Ivey, Steve Marshall, Jessica Ventiere. (Attachments: # 1 Exhibit D41)(Davis, James) Modified on 5/3/2022 to clean up text (cwl,). (Additional attachment(s) added on 5/3/2022: # 2 Corrected Certificate of Service) (cwl,). (Entered: 05/03/2022)
05/03/2022		Witness List by United States of America. (NO pdf attached to this entry - see doc 80 for

05/03/2022	82	TEXT ORDER: granting 42 Motion for Michael B. Shortnacy to Appear Pro Hac Vice; granting 43 Motion for Brent P. Ray to Appear Pro Hac Vice; granting 44 Motion for Abigail Hoverman Terry to Appear Pro Hac Vice; granting 45 Motion for Misty L. Peterson to Appear Pro Hac Vice; granting 46 Motion for Gilbert Olusegun Oladeinbo to Appear Pro Hac Vice; granting 47 Motion for Adam Reinke to Appear Pro Hac Vice; granting 48 Motion for Asaf Orr to Appear Pro Hac Vice; granting 49 Motion for Jessica Lynn Stone to Appear Pro Hac Vice; granting 50 Motion for Jennifer L. Levi to Appear Pro Hac Vice; granting 51 Motion for Cynthia Cheng-Wun Weaver to Appear Pro Hac Vice; granting 52 Motion for Scott D. McCoy to Appear Pro Hac Vice; granting 53 Motion for Sarah Warbelow to Appear Pro Hac Vice; granting 56 Motion for Christopher E. Mills to Appear Pro Hac Vice; granting 70 Motion for Michael A. Cantrell to Appear Pro Hac Vice. Signed by Honorable Judge Liles C. Burke on 5/3/2022. (NO pdf attached to this entry) (cwl,) (Entered: 05/03/2022)
05/03/2022	83	ORDER: the Plaintiffs' Motion for Leave to Proceed Pseudonymously (Doc. 6) is GRANTED. The Plaintiffs identified as Brianna Boe, Michael Boe, James Zoe, Zachary Zoe, Megan Poe, Allison Poe, Kathy Noe, Christopher Noe, and Rachel Koe, M.D. may proceed under pseudonyms. Signed by Honorable Judge Liles C. Burke on 5/3/2022. (cwl,) (Entered: 05/03/2022)
05/03/2022	84	Unopposed MOTION for Leave to File Exhibit Under Seal re 78 Exhibit List by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Attachments: # 1 Text of Proposed Order Proposed Order)(Eagan, Melody) Modified on 5/3/2022 to add link & clean up text (cwl,). (Entered: 05/03/2022)
05/03/2022	85	Joint MOTION to Dismiss <i>Defendant Kay Ivey</i> by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe, Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Kay Ivey, Steve Marshall, Jessica Ventiere. (Eagan, Melody) Modified on 5/3/2022 to add defs as filers (cwl,). (Entered: 05/03/2022)
05/03/2022	86	NOTICE of Appearance by Alyssa C. Lareau on behalf of United States of America (Lareau, Alyssa) (Entered: 05/03/2022)
05/03/2022	87	NOTICE of Filing Correct Defense Exhibit 41 re 81 Supplemental Exhibit List by Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Kay Ivey, Steve Marshall, Jessica Ventiere (Attachments: # 1 Exhibit)(Davis, James) Modified on 5/4/2022 to clean up text & to add link (cwl,). (Entered: 05/03/2022)
05/03/2022	88	TEXT ORDER: At the end of tomorrow's proceedings, the parties should be prepared to give their opening statements on Plaintiffs' motion for preliminary injunction. The parties' arguments shall not exceed 25 minutes each. Signed by Honorable Judge Liles C. Burke on 5/3/2022. (NO pdf attached to this entry) (cwl,) (Entered: 05/03/2022)
05/04/2022	89	REPLY BRIEF <i>IN SUPPORT OF PLAINTIFFS MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION</i> re 7 MOTION for Preliminary Injunction , MOTION for Temporary Restraining Order filed by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Eagan, Melody) Modified on 5/4/2022 to clarify text & add link (cwl,). (Entered: 05/04/2022)
05/04/2022	90	UNOPPOSED MOTION to Seal <i>PORTIONS OF PRELIMINARY INJUNCTION HEARING</i> by Rachel Koe, Megan Poe. (Attachments: # 1 Text of Proposed Order

		Proposed Order)(Eagan, Melody) Modified on 5/4/2022 to remove Brianna Boe, Paul A. Eknes-Tucker, Jane Moe, Kathy Noe, James Zoe as filers & clean up text (cwl,). (Entered: 05/04/2022)
05/04/2022	91	MOTION for Leave to File Brief of Amici Curiae by American Academy of Pediatrics, Alabama Chapter of the American Academy of Pediatrics, Academic Pediatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Nursing, American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ Equality, American College of Obstetricians and Gynecologists, American College of Osteopathic Pediatricians, American College of Physicians, American Medical Association, American Psychiatric Association, Association of American Medical Colleges, Association of Medical School Pediatric Department Chairs, The Endocrine Society, National Association of Pediatric Nurse Practitioners, Pediatric Endocrine Society, Society for Adolescent Health and Medicine, Society for Pediatric Research, Society of Pediatric Nurses, Societies for Pediatric Urology, World Professional Association for Transgender Health, American Pediatric Society. (Attachments: # 1 Exhibit Proposed Amicus Brief)(Ragsdale, Barry) Modified on 5/5/2022 to add as also filed on behalf of American Pediatric Society (amf,). (Entered: 05/04/2022)
05/04/2022	92	Amended Intervenor COMPLAINT , filed by United States of America. (Attachments: # 1 Certificate of the Attorney General)(Cheek, Jason) (Additional attachment(s) added on 5/5/2022: # 2 Certificate of Service) (amf,). (Entered: 05/04/2022)
05/04/2022		***PURSUANT TO THE 91 MOTION - Attorneys Cortlin H. Lannin, D. Jean Veta, William Isasi, Elizabeth Baia, Michael Lanosa, & Robert S. Vance, III for Academic Pediatric Association, Alabama Chapter of the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Nursing, Cortlin H. Lannin, D. Jean Veta, William Isasi, Elizabeth Baia, Michael Lanosa, Robert S. Vance, III for American Academy of Pediatrics, American Association of Physicians for Human Rights, Inc., American College of Obstetricians and Gynecologists, American College of Osteopathic Pediatricians, American College of Physicians, American Medical Association, American Pediatric Society, American Psychiatric Association, Association of American Medical Colleges, Association of Medical School Pediatric Department Chairs, National Association of Pediatric Nurse Practitioners, Pediatric Endocrine Society, Societies for Pediatric Urology, Society for Adolescent Health and Medicine, Society for Pediatric Research, Society of Pediatric Nurses, The Endocrine Society & World Professional Association for Transgender Health added. (No PDF attached to this entry) (amf,) (Entered: 05/05/2022)
05/04/2022	93	Minute Entry for proceedings held before Honorable Judge Liles C. Burke: Motion Hearing held on 5/4/2022 re 58 MOTION to Intervene filed by United States of America (PDF available for court use only). (Court Reporter Christine Decker.) (kcf,) (Entered: 05/05/2022)
05/05/2022		ORAL ORDER granting 85 Joint Motion to Dismiss Defendant Kay Ivey. Entered by Honorable Judge Liles C. Burke on 5/5/22. (dh) (Entered: 05/05/2022)
05/05/2022		Minute Entry for proceedings held before Honorable Judge Liles C. Burke: Evidentiary Hearing began on 5/5/2022 (NO PDF available; see final minute entry). (Court Reporter Christina Decker w/ND AL.) (dh) (Entered: 05/05/2022)
05/06/2022	96	Minute Entry for proceedings held before Honorable Judge Liles C. Burke: Evidentiary Hearing held on 5/6/2022 (PDF available for court use only). (Court Reporter Christina Decker w/ND AL.) (Attachments: # 1 Witness List, # 2 Pl. Exhibit List, # 3 PX1, # 4

		PX2, # 13 PX3, # 14 PX4, # 15 PX5, # 16 PX6, # 17 PX7, # 18 PX8, # 19 PX9, # 20 PX10, # 21 PX11, # 22 PX12, # 23 PX13, # 24 PX14, # 25 PX15, # 26 PX16, # 27 PX17, # 28 PX18, # 29 PX19, # 30 PX20, # 31 PX21, # 32 PX22, # 33 PX23, # 34 PX24, # 35 PX25, # 36 PX26, # 37 PX27, # 38 PX28, # 39 PX29, # 40 PX30, # 41 PX31, # 42 PX32, # 43 PX33, # 44 PX34, # 45 PX35, # 46 PX36, # 47 PX37, # 48 PX38, # 49 PX39, # 50 PX40, # 51 PX41, # 52 PX42, # 53 PX43, # 54 PX44, # 55 PX45, # 56 Intervenor (USA) Exhibit List, # 57 USA X1, # 58 USA X2, # 59 USA X3, # 60 USA X4, # 61 USA X5, # 62 USA X6, # 63 USA X7, # 64 USA X8, # 65 USA X9, # 66 USA X10, # 67 USA X11, # 68 USA X12, # 69 Def. Exhibit List, # 70 DX1, # 71 DX2, # 72 DX3, # 73 DX4, # 74 DX5, # 75 DX6, # 76 DX7, # 77 DX8, # 78 DX9, # 79 DX10, # 80 DX11, # 81 DX12, # 82 DX13, # 83 DX14, # 84 DX15, # 85 DX16, # 86 DX17, # 87 DX18, # 88 DX19, # 89 DX20, # 90 DX21, # 91 DX22, # 92 DX23, # 93 DX24, # 94 DX25, # 95 DX26, # 96 DX27, # 97 DX28, # 98 DX29, # 99 DX30, # 100 DX31, # 101 DX32, # 102 DX33, # 103 DX34, # 104 DX35, # 105 DX36, # 106 DX37, # 107 DX38, # 108 DX39, # 109 DX40, # 110 DX41, # 111 DX42 - CD Conventionally Filed) (dh) Modified on 6/8/2022 to reflect exhibits returned to counsel at conclusion of hearing. USB DRIVES (3) with all admitted exhibits to remain in court record. USB Drives and CD placed in accordion folder with file in Clerk's office. (dmn,) (Entered: 05/10/2022)
05/08/2022	94	PROCEDURAL ORDERS & STATUS OF FORTHCOMING OPINION: the United States's 58 motion to intervene is GRANTED; the 71 & 91 motions for leave to proceed as amici curiae are GRANTED; The Court will consider the briefs in ruling on the motions for a preliminary injunction; the 84 & 90 motions to seal are GRANTED; The Court has made very substantial progress toward crafting an opinion in this matter and expects to file the opinion by the end of this week, if not sooner. Signed by Honorable Judge Liles C. Burke on 5/8/2022. (amf,) (Entered: 05/08/2022)
05/08/2022	104	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of PRELIMINARY INJUNCTION HEARING VOLUME I (PDF ACCESS RESTRICTED FOR 90 DAYS) held on 5/5/2022, before Judge Liles C. Burke. Court Reporter/Transcriber Christina K. Decker, Telephone number 256-506-0085. Transcript may be viewed at the court public terminal or purchased through the Court Reporter/Transcriber before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER. NOTICE OF INTENT TO REQUEST REDACTION DUE WITHIN 7 BUSINESS DAYS. Redaction Request due 5/31/2022. Redacted Transcript Deadline set for 6/8/2022. Release of Transcript Restriction set for 8/8/2022. (cwl,) (Entered: 05/12/2022)
05/08/2022	105	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of PRELIMINARY INJUNCTION HEARING VOLUME II (PDF ACCESS RESTRICTED FOR 90 DAYS) held on 5/6/2022, before Judge Liles C. Burke. Court Reporter/Transcriber Christina K. Decker, Telephone number 256-506-0085. Transcript may be viewed at the court public terminal or purchased through the Court Reporter/Transcriber before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER. NOTICE OF INTENT TO REQUEST REDACTION DUE WITHIN 7 BUSINESS DAYS. Redaction Request due 5/31/2022. Redacted Transcript Deadline set for 6/8/2022. Release of Transcript Restriction set for 8/8/2022. (cwl,) (Entered: 05/12/2022)
05/08/2022	106	(SEALED TRANSCRIPT) NOTICE OF FILING OF OFFICIAL TRANSCRIPT of PRELIMINARY INJUNCTION HEARING VOLUME I held on 5/5/2022, before Judge Liles C. Burke. Court Reporter/Transcriber Christina K. Decker, Telephone number 256-506-0085. (cwl,) (Entered: 05/12/2022)
05/09/2022	95	BRIEF/MEMORANDUM in Opposition re 7 MOTION for Preliminary Injunction MOTION for Temporary Restraining Order <i>BRIEF OF 15 STATES AS AMICI CURIAE</i> filed by State of Alaska, State of Arizona, State of Arkansas, State of Georgia, State of

		Indiana, State of Louisiana, State of Mississippi, State of Missouri, State of Montana, State of Nebraska, State of Oklahoma, State of South Carolina, State of Texas, State of Utah, State of West Virginia. (Cantrell, Michael) (Entered: 05/09/2022)
05/11/2022	<u>97</u>	Motion for Robert S. Vance III to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3219952.) by Academic Pediatric Association, Alabama Chapter of the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Nursing, American Academy of Pediatrics, American Association of Physicians for Human Rights, Inc., American College of Obstetricians and Gynecologists, American College of Osteopathic Pediatricians, American College of Physicians, American Medical Association, American Pediatric Society, American Psychiatric Association, Association of American Medical Colleges, Association of Medical School Pediatric Department Chairs, National Association of Pediatric Nurse Practitioners, Pediatric Endocrine Society, Societies for Pediatric Urology, Society for Adolescent Health and Medicine, Society for Pediatric Research, Society of Pediatric Nurses, The Endocrine Society, World Professional Association for Transgender Health. (Ragsdale, Barry) Modified on 5/12/2022 to add attorney's name to text & clarify that Exhibit A is contained within the main PDF (cwl,). (Entered: 05/11/2022)
05/11/2022	<u>98</u>	Motion for D. Jean Veta to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3219954.) by Academic Pediatric Association, Alabama Chapter of the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Nursing, American Academy of Pediatrics, American Association of Physicians for Human Rights, Inc., American College of Obstetricians and Gynecologists, American College of Osteopathic Pediatricians, American College of Physicians, American Medical Association, American Pediatric Society, American Psychiatric Association, Association of American Medical Colleges, Association of Medical School Pediatric Department Chairs, National Association of Pediatric Nurse Practitioners, Pediatric Endocrine Society, Societies for Pediatric Urology, Society for Adolescent Health and Medicine, Society for Pediatric Research, Society of Pediatric Nurses, The Endocrine Society, World Professional Association for Transgender Health. (Ragsdale, Barry) Modified on 5/12/2022 to add attorney's name to text & clarify exhibit A is contained within the main PDF (cwl,). (Entered: 05/11/2022)
05/11/2022	<u>99</u>	Motion for Cortlin H. Lannin to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3219955.) by Academic Pediatric Association, Alabama Chapter of the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Nursing, American Academy of Pediatrics, American Association of Physicians for Human Rights, Inc., American College of Obstetricians and Gynecologists, American College of Osteopathic Pediatricians, American College of Physicians, American Medical Association, American Pediatric Society, American Psychiatric Association, Association of American Medical Colleges, Association of Medical School Pediatric Department Chairs, National Association of Pediatric Nurse Practitioners, Pediatric Endocrine Society, Societies for Pediatric Urology, Society for Adolescent Health and Medicine, Society for Pediatric Research, Society of Pediatric Nurses, The Endocrine Society, World Professional Association for Transgender Health. (Ragsdale, Barry) Modified on 5/12/2022 to add attorney's name to text & clarify exhibit A is contained within the main PDF (cwl,). (Entered: 05/11/2022)
05/11/2022	<u>100</u>	Motion for William Isasi to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3219959.) by Academic Pediatric Association, Alabama Chapter of the American Academy of Pediatrics, American Academy of Child and Adolescent

		Psychiatry, American Academy of Family Physicians, American Academy of Nursing, American Academy of Pediatrics, American Association of Physicians for Human Rights, Inc., American College of Obstetricians and Gynecologists, American College of Osteopathic Pediatricians, American College of Physicians, American Medical Association, American Pediatric Society, American Psychiatric Association, Association of American Medical Colleges, Association of Medical School Pediatric Department Chairs, National Association of Pediatric Nurse Practitioners, Pediatric Endocrine Society, Societies for Pediatric Urology, Society for Adolescent Health and Medicine, Society for Pediatric Research, Society of Pediatric Nurses, The Endocrine Society, World Professional Association for Transgender Health. (Ragsdale, Barry) Modified on 5/12/2022 to add attorney's name to text & clarify exhibit A is contained within the main PDF (cwl,). (Entered: 05/11/2022)
05/11/2022	101	Motion for Michael Lanosa to Appear Pro Hac Vice (Filing fee \$ 75.00 receipt number AALMDC-3219970.) by Academic Pediatric Association, Alabama Chapter of the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Nursing, American Academy of Pediatrics, American Association of Physicians for Human Rights, Inc., American College of Obstetricians and Gynecologists, American College of Osteopathic Pediatricians, American College of Physicians, American Medical Association, American Pediatric Society, American Psychiatric Association, Association of American Medical Colleges, Association of Medical School Pediatric Department Chairs, National Association of Pediatric Nurse Practitioners, Pediatric Endocrine Society, Societies for Pediatric Urology, Society for Adolescent Health and Medicine, Society for Pediatric Research, Society of Pediatric Nurses, The Endocrine Society, World Professional Association for Transgender Health. (Ragsdale, Barry) Modified on 5/12/2022 to add attorney's name to text & clarify exhibit A is contained within the main PDF (cwl,). (Entered: 05/11/2022)
05/11/2022	103	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of HEARING (PDF ACCESS RESTRICTED FOR 90 DAYS) held on 5/4/2022, before Judge Liles C. Burke. Court Reporter/Transcriber Christina K. Decker, Telephone number 256-506-0085. Transcript may be viewed at the court public terminal or purchased through the Court Reporter/Transcriber before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER. NOTICE OF INTENT TO REQUEST REDACTION DUE WITHIN 7 BUSINESS DAYS. Redaction Request due 6/1/2022. Redacted Transcript Deadline set for 6/13/2022. Release of Transcript Restriction set for 8/9/2022. (cwl,) (Entered: 05/12/2022)
05/13/2022	107	OPINION AND ORDER: the Court GRANTS in part PIFs' 7 motion for preliminary injunction and ENJOINS Dfts from enforcing Section 4(a)(1)-(3) of the Act pending trial. The Court GRANTS in part the United States's 62 motion for preliminary injunction to the same degree and effect. All other provisions of the Act remain enforceable. Signed by Honorable Judge Liles C. Burke on 5/13/2022. (wcl,) (Main Document 107 replaced on 5/17/2022 to correct a case number referenced in the PDF) (cwl,). (Main Document 107 replaced on 5/19/2022 to correct syntax) (cwl,). (Entered: 05/13/2022)
05/16/2022	108	NOTICE OF APPEAL by Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Kay Ivey, Steve Marshall, Jessica Ventiere of Order Granting Preliminary Injunction (Doc. 107) entered on 5/13/2022. (Filing fee \$ 505.00 receipt number AALMDC-3221733.) (LaCour, Edmund) Modified on 5/17/2022 to create link. (dmn,) (Entered: 05/16/2022)
05/17/2022	109	Appeal Instructions re 108 Notice of Appeal sent to Edmund LaCour, counsel for Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Kay Ivey, Steve Marshall,

		Jessica Ventiere. A copy of the Transcript Information Form must be mailed to each court reporter from whom you are requesting a transcript. (Attachments: # 1 Transcript Information Form)(dmn,) (Entered: 05/17/2022)
05/17/2022	110	NOTICE of Correction re 107 OPINION AND ORDER, to attach the correct main PDF document to correct a case number referenced in the PDF. (Attachments: # 1 Correct Main doc entry 107)(cwl,) (Entered: 05/17/2022)
05/18/2022	111	Transmission of 108 Notice of Appeal, 107 Order, and Docket Sheet to US Court of Appeals. (Attachments: # 1 Docket Sheet and Appeal Record)(dmn,) (Entered: 05/18/2022)
05/19/2022	112	NOTICE of Correction re 107 OPINION AND ORDER, to attach the correct main PDF document to correct syntax. (Attachments: # 1 Correct Main doc entry 107)(cwl,) (Entered: 05/19/2022)
05/20/2022	113	Joint MOTION to Dismiss <i>Governor Kay Ivey</i> by United States of America, Jessica Ventiere, Steve Marshall, Danny Carr, C. Wilson Baylock, Daryl D. Bailey, Tom Anderson. (Cheek, Jason) Modified on 5/23/2022 to add DFTs as filers (bes,). (Entered: 05/20/2022)
05/23/2022	114	USCA Case Number 22-11707-JJ for 108 Notice of Appeal, filed by Appellants Jessica Ventiere, Kay Ivey, C. Wilson Baylock, Tom Anderson, Daryl D. Bailey, Steve Marshall, Danny Carr. Fee Status: Fee Paid. No hearings to be transcribed. The appellant's brief is due on or before 6/27/2022. The appendix is due no later than 7 days from the filing of the appellant's brief. Awaiting Appellant's Certificate of Interested Persons due on or before 6/6/2022 as to Appellant Attorney General, State of Alabama. Awaiting Appellee's Certificate of Interested Persons due on or before 6/21/2022 as to Appellee Paul A. Eknes-Tucker. (dmn,) (Entered: 05/23/2022)
05/23/2022	115	TRANSCRIPT INFORMATION FORM re 108 Notice of Appeal by Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Kay Ivey, Steve Marshall, Jessica Ventiere with the following notation, "All necessary transcript(s) on file." (LaCour, Edmund) Modified on 5/24/2022 to include additional text. (dmn,) (Entered: 05/23/2022)
05/25/2022	116	ANSWER to 92 Intervenor Complaint, by Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Steve Marshall, Jessica Ventiere.(Seiss, Benjamin) (Entered: 05/25/2022)
05/31/2022	117	TEXT ORDER granting 113 Joint Motion to Dismiss Governor Kay Ivey. Signed by Honorable Judge Liles C. Burke on 5/31/2022. (No PDF attached to this entry) (bes,) (Entered: 05/31/2022)
06/06/2022	118	ORDER of USCA addressed to Jennifer Levi as to 108 Notice of Appeal, filed by Jessica Ventiere, Kay Ivey, C. Wilson Baylock, Tom Anderson, Daryl D. Bailey, Steve Marshall, Danny Carr, 11th Circuit Appeal No. 22-11707-JJ: Jennifer Levi is permitted to appear pro hac vice in this appeal, representing the Appellees, contingent upon her payment of the \$50.00 pro hac vice fee within 14 days of the date of this order. (dmn,) (Entered: 06/06/2022)
06/07/2022	120	ORDER of USCA as to 108 Notice of Appeal, filed by Jessica Ventiere, Kay Ivey, C. Wilson Baylock, Tom Anderson, Daryl D. Bailey, Steve Marshall, Danny Carr, 11th Circuit Appeal No. 22-11707-JJ: Appellants' "Unopposed Motion for Expedited Briefing and Appellate Review" is GRANTED. The Court DIRECTS the Clerk's Office to expedite the appeal for merits disposition purposes and place this appeal on the next available oral argument calendar. Briefing in this appeal shall proceed as follows: Appellants' initial brief is due by 6/27/2022, with the appendix due 7 days from the filing

		of the initial brief. Appellees' response briefs are due by 8/10/2022. Appellants' reply brief, if any, is due by 8/31/2022. (dmn,) (no pdf) (Entered: 06/08/2022)
06/08/2022	119	TEXT ORDER: On or before 6/22/2022, the parties shall file their Rule 26(f) report or the court will set the schedule for them on 6/23/2022. Signed by Honorable Judge Liles C. Burke on 6/8/2022. (No PDF attached to this entry) (bes,) (Entered: 06/08/2022)
06/08/2022		Pursuant to F.R.A.P. 11(c), the Clerk of the District Court for the Middle District of Alabama certifies that the record is complete for purposes of this appeal re: 108 Notice of Appeal, Appeal No. 22-11707-JJ. The entire record on appeal is available electronically with the exception of: Doc. 96 , Exhibit DX42 CD, VIDEO. (dmn,) (Entered: 06/08/2022)
06/09/2022	121	NOTICE of Appearance by Eliza Dermody on behalf of United States of America (Dermody, Eliza) (Entered: 06/09/2022)
06/16/2022	122	NOTICE of Appearance by Kaitlin N Toyama on behalf of United States of America (Toyama, Kaitlin) (Entered: 06/16/2022)
06/16/2022	123	NOTICE of Appearance by Renee Michelle Williams on behalf of United States of America (Williams, Renee) (Entered: 06/16/2022)
06/21/2022	124	Consent MOTION to unseal Dr. Koe's testimony from the preliminary injunction hearing re 106 Transcript by Tom Anderson, Daryl D. Bailey, C. Wilson Baylock, Danny Carr, Steve Marshall, Jessica Ventiere. (Attachments: # 1 Text of Proposed Order)(Bowdre, Alexander) (Entered: 06/21/2022)
06/22/2022	125	REPORT of Rule 26(f) Planning Meeting. (Eagan, Melody) (Entered: 06/22/2022)
06/24/2022	126	MOTION to Withdraw as Attorney <i>for Attorney Gilbert Olusegun Oladeinbo</i> by Brianna Boe, Paul A. Eknes-Tucker, Rachel Koe, Jane Moe, Kathy Noe, Megan Poe, James Zoe. (Attachments: # 1 Text of Proposed Order)(Oladeinbo, Gilbert) Modified on 6/25/2022 to clarify the docket text (bes,). (Entered: 06/24/2022)

PACER Service Center			
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Description:	Docket Report	Search Criteria:	2:22-cv-00184-LCB-SRW
Billable Pages:	30	Cost:	3.00

DOC. 1

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

2022 APR 19 P 4:13

DEBRA P. HACKETT, CLK
U.S. DISTRICT COURT
MIDDLE DISTRICT ALA

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-RAH-SRW

**COMPLAINT FOR
DECLARATORY AND
INJUNCTIVE RELIEF**

COMPLAINT

Reverend 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. (collectively, “Plaintiffs”), bring this Action for Declaratory and Injunctive Relief against Defendants 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 (collectively, “Defendants”), respectfully stating as follows:

PRELIMINARY STATEMENT

1. This Action is a federal constitutional challenge to the State of Alabama’s Vulnerable Child Compassion and Protection Act (the “Act”), passed by the Alabama Legislature on April 7, 2022, and signed into law by Governor Kay Ivey on April 8, 2022. Unless enjoined, the Act takes effect May 8, 2022.

2. The Act intrudes into the right of parents to make medical decisions to ensure the health and wellbeing of their children. It does so by prohibiting parents from seeking and obtaining appropriate medical care for their children and subjecting them to criminal prosecution if they do so.

3. The Act also targets transgender minors by imposing criminal penalties on any individuals, including parents and health care providers, who obtain or provide medical treatments essential to the minors' health care needs.

4. Further, the Act is worded broadly, criminalizing anyone who "causes" an individual to receive the prohibited medical treatments, so that doctors, parents, and even clergy cannot discuss, advise, or counsel parents of transgender minors about how to address their children's medical needs.

5. Plaintiffs seek declaratory and injunctive relief to enjoin the enforcement of the Act. Without the injunctive relief sought, Plaintiffs will experience irreparable injury.

PARTIES

I. Transgender Plaintiffs and Their Parents

6. Plaintiff Brianna Boe is and has at all relevant times been a resident of Montgomery County, Alabama. She is the mother of Plaintiff Michael Boe, a 12-year-old transgender boy for whom she also appears in this case as his next friend. Because of concerns about potential criminal liability, as well as her and her child's

privacy and safety, Brianna Boe and Michael Boe seek to proceed in this case under a pseudonym. *See* Motion to Proceed Pseudonymously, filed concurrently herewith.

7. Plaintiff James Zoe is and has at all relevant times been a resident of Jefferson County, Alabama. James is the father of Plaintiff Zachary Zoe, a 13-year-old transgender boy for whom he also appears in this case as his next friend. Because of concerns about potential criminal liability, as well as his and his child's privacy and safety, James Zoe and Zachary Zoe seek to proceed in this case under a pseudonym. *See* Motion to Proceed Pseudonymously, concurrently filed herewith.

8. Plaintiff Megan Poe is and has at all relevant times been a resident of Cullman County, Alabama. She is the mother of Plaintiff Allison Poe, a 15-year-old transgender girl, for whom she also appears in this case as her next friend. Because of concerns about potential criminal liability, as well as her and her child's privacy and safety, Megan Poe and Allison Poe seek to proceed in this case under a pseudonym. *See* Motion to Proceed Pseudonymously, filed concurrently herewith.

9. Plaintiff Kathy Noe is and has at all relevant times been a resident of Lee County, Alabama. She is the mother of Plaintiff Christopher Noe, a 17-year-old transgender boy, for whom she also appears in this case as his next friend. Because of concerns about potential criminal liability, as well as her and her child's privacy and safety, Kathy Noe and Christopher Noe seek to proceed in this case under a pseudonym. *See* Motion to Proceed Pseudonymously, filed concurrently herewith.

II. *Healthcare Provider Plaintiffs*

10. Plaintiff Jane Moe is a Ph.D. level, licensed clinical child psychologist with over 20 years of experience who maintains a practice in Jefferson County, Alabama. Dr. Moe works in a hospital setting within the University of Alabama at Birmingham (“UAB”) system where she regularly provides mental health care to children and adolescents, including transgender youth. Dr. Moe also resides in Jefferson County, Alabama. Because of concerns about potential criminal liability, as well as the privacy and safety of her patients, Dr. Moe seeks to proceed in this case under a pseudonym. *See Motion to Proceed Pseudonymously*, filed concurrently herewith.

11. Plaintiff Rachel Koe, M.D., is a board-certified pediatrician with over 10 years of experience. Dr. Koe is a pediatrician in southeast Alabama where she regularly treats children and adolescents. She also refers transgender patients and their parents to healthcare providers who specialize in working with transgender patients, including to the Children’s Hospital of Alabama and medical staff at UAB Hospital, which are both located in Jefferson County, Alabama. Dr. Koe resides and works in the 12th Judicial Circuit of Alabama. Because of concerns about potential criminal liability, as well as the privacy and safety of her patients, Dr. Koe seeks to proceed in this case under a pseudonym. *See Motion to Proceed Pseudonymously*, filed concurrently herewith.

III. *Reverend Paul A. Eknes-Tucker*

12. Plaintiff Reverend Paul A. Eknes-Tucker is a Senior Pastor at Pilgrim Church in Birmingham, Alabama. In his role as Senior Pastor, Reverend Eknes-Tucker has provided pastoral counseling to parents of transgender children who are congregants at his church as well as members of the Birmingham community. Reverend Eknes-Tucker counsels parents of transgender children about religious faith-based teachings about love, support, and respect for all persons. He also supports parents who are seeking medical treatment for their child's gender dysphoria.

IV. *Defendants*

13. Defendant Kay Ivey is the Governor of the State of Alabama. Governor Ivey is sued in her official capacity as Governor of Alabama.

14. Defendant Steve Marshall is the Attorney General of the State of Alabama. He is the chief law enforcement officer of the State with the power to initiate criminal action to enforce the Act. In his capacity as Attorney General, Mr. Marshall has the ability to enforce the Act. Mr. Marshall is sued in his official capacity as Attorney General of Alabama.

15. Defendant Daryl D. Bailey is the District Attorney of Montgomery County, Alabama. He is the chief law enforcement officer of Montgomery County, who prosecutes all felony and some misdemeanor criminal cases which occur within

Montgomery County. In his capacity as District Attorney, Mr. Bailey has the ability to enforce the Act. Mr. Bailey is sued in his official capacity as District Attorney of Montgomery County, Alabama.

16. Defendant C. Wilson Baylock is the District Attorney for the 32nd Judicial Circuit overseeing Cullman County, Alabama. He is the chief law enforcement officer of Cullman County who prosecutes all felony criminal cases that occur within Cullman County. His prosecutorial authority extends to the enforcement of the Act within Cullman County. Defendant Baylock is sued in his official capacity as District Attorney of Cullman County, Alabama.

17. Defendant Jessica Ventiere is the District Attorney for Lee County, Alabama. She is the chief law enforcement officer of Lee County, who prosecutes all felony and some misdemeanor criminal cases which occur within Lee County. In her capacity as District Attorney, Ms. Ventiere has the ability to enforce the Act. Ms. Ventiere is sued in her official capacity as District Attorney of Lee County, Alabama.

18. Defendant Tom Anderson is the District Attorney for the 12th Judicial Circuit overseeing Coffee County and Pike County, Alabama. He is the chief law enforcement officer of Coffee and Pike Counties, who prosecutes all felony and some misdemeanor criminal cases which occur within Coffee and Pike Counties. In his capacity of District Attorney, Mr. Anderson has the ability to enforce the Act.

Mr. Anderson is sued in his official capacity as the District Attorney of the 12th Judicial Circuit.

19. Defendant Danny Carr is the District Attorney of Jefferson County, Alabama. He is the chief law enforcement officer of Jefferson County who prosecutes all felony criminal cases that occur within the Birmingham Division of Jefferson County, including the City of Birmingham. In his capacity as District Attorney, Mr. Carr has the ability to enforce the Act. Mr. Carr is sued in his official capacity as District Attorney of Jefferson County, Alabama.

20. Defendants each have separate and independent authority to enforce the Act within their respective jurisdictions.

JURISDICTION AND VENUE

21. Plaintiffs seek redress for the deprivation of their rights secured by Section 1557 of the Affordable Care Act, the United States Constitution, and the equitable powers of this Court to enjoin unlawful official conduct. This action is instituted pursuant to 42 U.S.C. § 18116 and 42 U.S.C. § 1983 to enjoin Defendants from enforcing the Act and for a declaration that the Act violates federal law. Therefore, this Court has subject matter jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1343.

22. This Court has personal jurisdiction over Defendants because Defendants are domiciled in Alabama and the denial of Plaintiffs' rights guaranteed by federal law occurred within Alabama.

23. All Defendants reside in Alabama, and, upon information and belief, Defendants Ivey, Marshall, Bailey, Ventiere, and Anderson reside in this judicial district. Therefore, venue is proper in this district pursuant to 28 U.S.C. § 1391(b)(1).

24. If enforced, the Act would violate the federal statutory and constitutional rights of Plaintiffs in this judicial district. Therefore, venue is also proper in this district pursuant to 28 U.S.C. § 1391(b)(2).

25. This Court has the authority to enter a declaratory judgment and to provide preliminary and permanent injunctive relief pursuant to Fed. R. Civ. P. 57 and 65, 28 U.S.C. §§ 2201 and 2202, and this Court's inherent equitable powers.

FACTUAL ALLEGATIONS

I. Gender Identity and Gender Dysphoria

26. Gender identity is an innate, internal sense of one's sex and is an immutable aspect of a person's identity. Everyone has a gender identity. Most people's gender identity is consistent with their birth sex. Transgender people, however, have a gender identity that differs from their birth sex.

27. Gender dysphoria is the clinical diagnosis for the distress that arises when a person's gender identity does not match their birth sex. To receive a

diagnosis of gender dysphoria, a young person must meet the criteria set forth in the Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. 2013) ("DSM-5").¹ If left untreated, gender dysphoria can cause anxiety, depression, and self-harm, including suicidality.

28. In fact, 56% of transgender youth reported a previous suicide attempt and 86% of them reported suicidality. See Austin, Ashley, Shelley L. Craig, Sandra D. Souza, and Lauren B. McInroy (2022), *Suicidality Among Transgender Youth: Elucidating the Role of Interpersonal Risk Factors*. J. of Interpersonal Violence. Vol. 37 (5–6) NP2696-NP2718.

29. Research has shown that an individual's gender identity is biologically based and cannot be changed. In the past, mental health professionals sought to treat gender dysphoria by attempting to change the person's gender identity to match their birth sex; these efforts were unsuccessful and caused serious harms. Today, the medical profession generally recognizes that such efforts put minors at risk of serious harm, including dramatically increased rates of suicidality.

¹ Earlier editions of the DSM included a diagnosis referred to as "Gender Identity Disorder." The DSM-5 noted that Gender Dysphoria "is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity *per se*. Being diagnosed with gender dysphoria "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities." Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender & Gender Variant Individuals* (2012).

30. Gender dysphoria is highly treatable. Healthcare providers who specialize in the treatment of gender dysphoria follow a well-established standard of care that has been adopted by the major medical and mental health associations in the United States including, but not limited to, the American Medical Association, the American Academy of Pediatrics, the American Association of Child and Adolescent Psychiatrists, the Pediatric Endocrine Society, the American Psychiatric Association, the American Psychological Association, and the Endocrine Society.

31. The standards of care for treatment of transgender people, including transgender youth, were initially developed by the World Professional Association for Transgender Health (“WPATH”), an international, multidisciplinary, professional association of medical providers, mental health providers, researchers, and others, with a mission of promoting evidence-based care and research for transgender health, including the treatment of gender dysphoria. WPATH published the most recent edition of the Standards of Care for the treatment of gender dysphoria in minors and adults in 2011 and is in the process of finalizing a revised edition of the Standards of Care, which will likely be published later this year.

32. The Endocrine Society has also promulgated a standard of care for the provision of hormone therapy as a treatment for gender dysphoria in minors and adults. See Wylie C. Hembree, et al., *Endocrine Treatment of Gender-*

Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, 102 J. Clin. Endocrinol. Metab. 3869 (2017).

33. The American Medical Association, the American Academy of Pediatrics, the American Association of Child and Adolescent Psychiatrists, the Pediatric Endocrine Society, the American Psychiatric Association, the American Psychological Association, and other professional medical organizations also follow the WPATH and Endocrine Society standards of care.

34. The treatment of gender dysphoria is designed to reduce a transgender person's psychological distress by permitting them to live in alignment with their gender identity. Undergoing treatment for gender dysphoria is commonly referred to as transition. There are several components to the transition process: social, legal, medical, and surgical. Each of these components is part of the medically approved process for transition, some or all of which a transgender person may undertake as part of their transition.

35. Social transition typically involves adopting a new name, pronouns, hairstyle, and clothing that match that person's gender identity, and treating that person consistent with their gender identity in all aspects of their life, including home, school, and everyday life. Following those steps, transgender people often obtain a court order legally changing their name and, where possible, changing the sex listed on their birth certificate and other identity documents.

36. For transgender people who have begun puberty, it may be appropriate for them to start taking puberty-blocking medication and later hormone-replacement therapy to ensure their body develops in a manner consistent with their gender identity.

37. Finally, surgical treatment may in some cases be part of essential medical care for a transgender individual. The only surgical treatment available to transgender minors is male chest reconstruction surgery, a procedure to remove existing breast tissue and create a male chest contour for transgender males. Like all treatments for gender dysphoria, male chest reconstruction surgery is safe and effective in treating gender dysphoria. The medical necessity of surgical care is determined on a case-by-case basis that considers the age of the patient, medical need, and appropriateness of the procedure relative to the psychological development of the individual.

38. Longitudinal studies have shown that children with gender dysphoria who receive essential medical care show levels of mental health and stability consistent with those of non-transgender children. Lily Durwood, et al., *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*, 56 J. Am. Acad. Child & Adolescent Psychiatry 116 (2017); Kristina Olson, et al., *Mental Health of Transgender Children who are Supported in Their Identities*, 137 Pediatrics 1 (2016). In contrast, children with gender dysphoria who do not receive appropriate

medical care are at risk of serious harm, including dramatically increased rates of suicidality and serious depression.

II. *The Alabama Vulnerable Child Compassion and Protection Act*

39. On April 8, 2022, Defendant Kay Ivey signed the Act into law, and the Act is scheduled to become effective on May 8, 2022.

40. The Act prevents parents from consenting to, and healthcare professionals from providing, well-established medically necessary care. The Act also applies to any individual who “cause[s]” such care to be provided to a transgender minor.

41. Specifically, subsection 4(a) of the Act provides that:

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 appearance or 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 sex, including metoidioplasty, phalloplasty, and vaginoplasty.
- (6) Removing any healthy or non-diseased body part or tissue, except for a male circumcision.

42. A violation of subsection 4(a) of the Act is a Class C felony, punishable upon conviction by up to 10 years imprisonment or a fine of up to \$15,000.

43. As a result of subsection 4(a) of the Act, medical professionals, including the Healthcare Provider Plaintiffs, and parents of transgender minors, including the Parent Plaintiffs, are forced to choose between withholding medically necessary treatment from their minor transgender patients or children, on the one hand, or facing criminal prosecution, on the other. Moreover, the broad language of the Act imposes content-based restrictions on discussions, counseling, or referrals regarding gender dysphoria treatments for well-recognized in the medical community that may result in such care being provided to a transgender minor.

III. *The Act Will Irreparably Harm the Plaintiffs*

Brianna Boe and her son Michael Boe

44. Michael Boe is a 12-year-old transgender boy who resides with his mother in Montgomery County, Alabama.

45. In his early years, Michael was a happy, outgoing child. But at nine years old, Michael became depressed and anxious. Michael also started struggling academically and socially.

46. 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. He also reported that he was being bullied in school. Brianna placed Michael in a new school for the following school year and brought him to a therapist to help him with his depression.

47. Michael began to talk with Brianna about his male gender identity and the distress and discomfort he was experiencing as he entered puberty, as his body began to develop in ways that were inconsistent with his sense of self.

48. In June 2021, Michael told his mother that he is transgender. 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.

49. Since Michael began to socially transition, his mood has improved greatly. His therapist recently recommended that Michael be evaluated for additional medical treatment to address the mismatch between his body and his gender identity.

50. In February 2022, Brianna reached out to the Children's Hospital of Alabama to make an initial appointment for Michael. If this law goes into effect,

however, that appointment will be cancelled, and Michael will have to further delay his assessment for critical medical care.

James Zoe and his son Zachary Zoe

51. James Zoe was born and raised in Alabama and attended the University of Alabama at Birmingham. Like his dad, Zachary was born in Alabama and has lived in the state his entire life. Zachary resides half-time with James and his stepmother in Jefferson County, and half-time with his biological mother and stepfather in St. Clair County.

52. Zachary is a 13-year-old transgender boy in seventh grade. He is a bright boy with a close group of friends, and is interested in video games and art.

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

54. Around a year later, he started puberty. Zachary was distressed that he was developing breasts and had to deal with his period. This caused him to become even more 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.

James and Zachary's other parents did not initially understand why he was withdrawn or why he was uncomfortable with his body.

55. 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, which brought Zachary a greater sense of self-awareness and self-acceptance, allowing him to feel more at ease and happy. It also gave him the confidence he needed to tell his parents that he is transgender. Both sets of parents were supportive of Zachary, using his chosen name and male pronouns.

56. Zachary's social transition has been very positive for him. He uses a chest binder and appears and dresses like other boys his age. Since he came out, Zachary has blossomed into a happier and more outgoing child.

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

58. Continuing to receive puberty-blockers and progressing with medical treatments for his gender dysphoria, as deemed appropriate by his treating providers, is essential for Zachary's mental health. If the Act were enforced, Zachary's parents would 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. Zachary's parents know that if Zachary is not able to receive the medications or treatments necessary to treat his gender dysphoria, his life will be disrupted, and his physical and mental health will suffer.

Megan Poe and Allison Poe

59. Allison Poe is a 15-year-old transgender girl who resides with her mother, Megan Poe, in Cullman County, Alabama.

60. As a young child, Allison showed interest in girls' toys and clothing. Thinking this was a phase, her parents initially refused to buy Allison any girl toys. Without asking, Allison's grandmother bought Allison a Barbie doll. Allison was so happy and carried it everywhere.

61. When the family returned to the United States from her father's military deployment abroad, Allison would become very upset when her mother refused to buy her girls' clothes. As a compromise, Megan bought Allison a few girls' toys. Eventually, Allison's father found them and attempted to throw them away, but Allison's brother snuck them back into the house.

62. When Allison was around nine years old, her personality began to change significantly. She became withdrawn, quiet, showed signs of depression, and regularly commented that she wanted to die. She also stopped eating regularly. Allison's actions became so worrisome to Megan that she consulted with a

pediatrician. The pediatrician suggested that Allison may be transgender and referred them to the gender clinic at UAB Hospital.

63. After evaluating Allison, the team of clinicians educated Megan about what Allison was experiencing and gave her advice about how to support Allison. That visit was a turning point for Megan. She became supportive of Allison, helping her redecorate her room and buying her girls' clothes. The first time Allison came out of her room in girls' clothes, she was beaming with joy.

64. By fifth grade, many of Allison's peers had started showing the first signs of puberty, and Allison became scared about going through a male puberty. In anticipation of her starting puberty, Allison started the process to be evaluated for puberty-blocking medication.

65. About seven months ago, just as Allison was beginning high school, she was evaluated for and eventually started on estrogen. Her mental health has improved dramatically; she is confident, social, and doing well in school.

66. If the Act is allowed to go into effect, Allison's medical care will be disrupted, which would cause Allison extreme anxiety and distress. She will develop physical traits that are inconsistent with her identity as a girl that will require her to undergo otherwise avoidable surgeries in the future as an adult.

Kathy Noe and Christopher Noe

67. Christopher Noe is a 17-year-old transgender boy who resides with his mother, Kathy Noe, in Lee County, Alabama. Christopher and Kathy have deep roots in Alabama, having moved to the State just before Christopher turned 4 years old. Kathy is former active-duty military, while Christopher's father is still active-duty military and is deployed abroad.

68. Since Christopher was a toddler, he resisted attempts to dress him as a girl. For example, he refused to attend his sixth-grade graduation because doing so meant he would have to wear a dress.

69. As Christopher began to enter puberty, his distress at the changes his body was undergoing and at being made to present as female intensified.

70. When Christopher was 14, he told his mother he is transgender. Kathy found Christopher a therapist experienced in working with transgender young people. The therapist helped both Christopher and Kathy navigate the beginning stages of Christopher's transition.

71. About a year later, Christopher came out to his father as transgender. Christopher's father struggled initially, but because of his love for Christopher, his father began to accept Christopher for who he is.

72. With his father's support, Kathy took Christopher to a physician to begin the evaluation for hormone-replacement therapy. Because Kathy and

Christopher live close to the Alabama-Georgia state line, Christopher's doctors are in Columbus, Georgia. Christopher's prescriptions, however, are filled at a pharmacy in Alabama.

73. Christopher began hormone replacement therapy in March 2022. Christopher has been noticeably happier. He is bubbly and more outgoing and is confident at work and around other people.

74. 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.

Dr. Rachel Koe

75. Dr. Rachel Koe is a board-certified pediatrician in southeast Alabama. Over the past decade, Dr. Koe has treated a handful of transgender patients, including one current patient for whom she provides primary care.

76. Depending on the needs of the patient, Dr. Koe has referred patients and their parents to local mental health providers as well as the gender clinic at UAB Hospital. Even after referral, Dr. Koe remains involved with her patients' care. For example, Dr. Koe's office draws blood for their patient's regular blood work in advance of appointments with the gender clinic. Additionally, she and her staff provide support to patients who need assistance in self-administering injectable medications like testosterone.

77. Dr. Koe is familiar with the standards of care for the treatment of gender dysphoria and the medical literature regarding those treatments. She has also seen the significant positive effects medical treatment for gender dysphoria has had on the health and wellbeing of her patients.

78. If the Act goes into effect, Dr. Koe would be forced to choose between complying with the Act and the medical needs of her current and any future transgender patients whose mental and physical health will deteriorate if denied ongoing medical treatment for their gender dysphoria. The Act forces Dr. Koe to violate her professional and ethical obligations as a physician by denying her patients access to a course of treatment that is evidence-based and consistent with the established standards of care.

79. Dr. Koe would also be required to curtail her speech as she would no longer be allowed to provide accurate and comprehensive information to parents and about medically necessary treatment options for gender dysphoria and would be prohibited from making referrals to specialists who could prescribe those treatments.

80. Changing her practice in those ways would also require Dr. Koe to violate her legal obligation as a Medicaid provider to not discriminate in the provision of medical care to her transgender patients. Ignoring that obligation would jeopardize her ability to provide primary medical care in rural southeast Alabama.

Jane Moe, Ph.D.

81. Dr. Jane Moe is a doctoral-level clinical child psychologist with a specialty in child development who currently practices in a hospital setting within the UAB System. Dr. Moe has been a practicing clinical psychologist for twenty years and has experience working with children and adolescents with a variety of mental health issues. For the past two years, part of Dr. Moe's practice has been dedicated to mental health treatment and evaluation of transgender young people.

82. Dr. Moe's work with transgender patients is guided by the well-established standards of care and the hospital's informed-consent protocol. Her assessment process engages both the patient and the patient's parents and requires a minimum of three to four visits. It is quite common for the assessment to require additional visits, but that determination is made on a case-by-case basis and dependent on the needs of the patient and the patient's family.

83. In order to conduct her assessment, Dr. Moe gathers information about the patient from questionnaires, rating scales, and discussions with the patient and the patient's family. Pulling from multiple sources provides Dr. Moe with the information she needs to determine whether the patient meets the diagnostic criteria for gender dysphoria as outlined in the DSM-5.

84. Once she has made, or confirmed, the diagnosis, Dr. Moe then begins taking the patient and the patient's parents through the informed-consent protocol.

As required by the protocol, she has detailed discussions about the risks and benefits of the particular medical treatment being considered by the patient and their medical provider. Because of the large amount of information that is reviewed as part of the informed-consent protocol, this discussion can occur over multiple sessions and sometimes Dr. Moe will have separate sessions with the patient and the parent(s) to give each person an opportunity to ask questions and engage with the information being provided.

85. After completing the informed-consent protocol, Dr. Moe writes a letter to the patient's medical provider detailing the results of her assessment. That letter will include, for example, an overview of the patient's mental health and, if needed, recommendations on follow up mental health care. Although the letter discusses a patient's readiness to proceed with treatment, Dr. Moe always recommends in the letter that the medical provider conduct a further assessment before initiating treatment.

86. If enforced, the Act will prevent Dr. Moe from continuing to treat transgender patients in a manner that is consistent with the applicable standards of care. She would not be able to provide the level of detailed information or engage in in-depth conversations with her transgender patients or the patient's parents about medical treatments for gender dysphoria. Practicing this way would require Dr. Moe

to violate her professional and ethical obligations. Unwilling to do so, Dr. Moe fears that she will be subject to criminal prosecution under the Act.

87. Dr. Moe is also concerned for the health and wellbeing of her patients should the Act go into effect. She has witnessed the significant distress her patients experience before starting medical treatment and the tremendous positive effects those treatments have on her patients' mental health. Without access to that critical care, Dr. Moe worries that her patients' mental health will deteriorate in ways that will interfere with their ability to function and cause lasting harm to their health and wellbeing, including developing substance use issues and increased suicidality.

Reverend Paul A. Eknes-Tucker

88. Reverend Eknes-Tucker is the Senior Pastor at Pilgrim Church in Birmingham, Alabama. The church was established in 1903 and is part of the United Church of Christ. The core tenet of the congregation is to love and support all people to be their true and authentic selves. As such, his faith compels him to support and encourage parents to love and affirm their transgender children.

89. As a pastor, Reverend Eknes-Tucker provides pastoral counseling to families of transgender children who are often uncertain about what guidance their faith can provide, as they try to figure out how to support their children who are experiencing gender dysphoria.

90. During these pastoral counseling sessions, parents of transgender children share their worries and fears as well as hopes and aspirations for their transgender children's future. Reverend Eknes-Tucker and the parents extensively discuss the application of their faith's teachings to each family's unique circumstances. He also strives to answer questions and provide information to help parents make decisions about what is best for their children, including whether to consent to particular medical treatments, by accounting for their child's spiritual wellbeing in that decision-making process.

91. This includes counseling parents to seek the advice of other professionals, such as medical providers and mental health professionals, as needed, to further assist their children.

92. If this Act comes into effect, Reverend Eknes-Tucker is concerned for the spiritual and mental wellbeing of families he has counseled because he has seen the benefits that pastoral counseling has provided the families he has worked with. Because of the content of Reverend Eknes-Tucker's pastoral counseling sessions with parents raising transgender children, he will face criminal penalties for his pastoral work as it could "cause" a transgender minor to begin medical treatments for their gender dysphoria.

CLAIMS FOR RELIEF

COUNT I

Deprivation of Substantive Due Process
Parent Plaintiffs Against Defendants in Their Official Capacities
Violation of Parent Plaintiffs' Right to Direct the Upbringing of Their Children
U.S. Const. Amend. XIV

93. Plaintiffs incorporate all preceding paragraphs of the Complaint as if set forth fully herein.

94. The Parent Plaintiffs bring this Count against all Defendants.

95. The Fourteenth Amendment to the United States Constitution protects the rights of parents to make decisions “concerning the care, custody, and control of their children.” *Troxel v. Granville*, 530 U.S. 57, 66, 120 S. Ct. 2054, 147 L.Ed.2d 49 (2000). That fundamental right includes the liberty to make medical decisions for their minor children, including the right to obtain medical treatments that are recognized to be safe, effective, and medically necessary to protect their children’s health and well-being.

96. The Act violates this fundamental right by preventing the Parent Plaintiffs from obtaining medically necessary care for their minor children.

97. By intruding upon parents’ fundamental right to direct the upbringing of their children, the Act is subject to strict scrutiny.

98. Defendants have no compelling justification for preventing parents from ensuring their children can receive essential medical care. The Act does not advance any legitimate interest, much less a compelling one.

COUNT II

Deprivation of Equal Protection

All Plaintiffs Against Defendants in Their Official Capacities

U.S. Const. Amend. XIV

99. Plaintiffs incorporate all preceding paragraphs of the Complaint as if set forth fully herein.

100. All Plaintiffs bring this Count against all Defendants.

101. The Equal Protection Clause of the Fourteenth Amendment, enforceable pursuant to 42 U.S.C. § 1983, provides that no state shall “deny to any person within its jurisdiction the equal protection of the laws.” U.S. Const. Amend. XIV, § 1.

102. The Act singles out transgender minors and prohibits them from obtaining medically necessary treatment based on their sex and transgender status.

103. The Act also treats transgender minors differently and less favorably than non-transgender minors by allowing minors who are not transgender to obtain the same medical treatments that are prohibited when medically necessary for transgender minors.

104. Under the Equal Protection Clause, government classifications based on sex are subject to heightened scrutiny and are presumptively unconstitutional.

105. Transgender-based government classifications are subject, at a minimum, to heightened scrutiny because they are also sex-based classifications.

106. Because transgender people have obvious, immutable, and distinguishing characteristics, including having a gender identity that is different than their birth sex, they comprise a discrete group. This defining characteristic bears no relation to a transgender person's ability to contribute to society. Nevertheless, transgender people have faced historical discrimination and have been unable to secure equality through the political process.

107. As such, transgender classifications are subject to strict scrutiny.

108. The Act does nothing to protect the health or well-being of minors. To the contrary, the Act undermines the health and well-being of transgender minors by denying them essential medical care.

109. The Act is not narrowly tailored to further a compelling government interest and is not substantially related to any important governmental interest. Moreover, the Act is not even rationally related to a governmental interest. Accordingly, the Act violates the Equal Protection Clause of the Fourteenth Amendment.

COUNT III

Preemption

**Healthcare Provider Plaintiffs, Parent Plaintiffs, and Transgender Plaintiffs Against
Defendants in Their Official Capacities**

42 U.S.C. § 18116

110. Plaintiffs incorporate all preceding paragraphs of the Complaint as if set forth fully herein.

111. Healthcare Provider Plaintiffs, Parent Plaintiffs, and Transgender Plaintiffs bring this Count against all Defendants.

112. Under Section 1557 of the Affordable Care Act, “an individual shall not . . . 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, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)” on the basis of sex. 42 U.S.C. § 18116.

113. The prohibition on sex discrimination in Section 1557 of the Affordable Care Act protects transgender individuals from discrimination by healthcare providers, including physicians and hospitals.

114. The Parent Plaintiffs obtain medical care for their children, the Transgender Plaintiffs, from providers who are recipients of federal financial assistance and therefore subject to the non-discrimination requirements of Section 1557 of the Affordable Care Act.

115. The Act subjects the Transgender Plaintiffs and the Parent Plaintiffs to unlawful sex discrimination by preventing Plaintiff Parents from obtaining

medically necessary care for their children, the Transgender Plaintiffs, because of the children's transgender status and by requiring their healthcare providers to discriminate against the children because they are transgender. As such, the Act conflicts with the non-discrimination requirements of Section 1557. It also conflicts with and undermines the purposes and goals of Section 1557.

116. In addition, as providers for transgender beneficiaries of Alabama Medicaid, the Healthcare Provider Plaintiffs are recipients of federal financial assistance and therefore subject to the non-discrimination requirements of Section 1557 of the Affordable Care Act.

117. It is impossible for the Healthcare Provider Plaintiffs to continue to comply with their obligations under Section 1557 and also comply with the restrictions imposed by the Act. On the one hand, refusing to comply with the Act would bring them into compliance with Section 1557, but subject them to criminal penalties under the Act. On the other hand, complying with the Act would subject the Healthcare Plaintiffs to civil liability for discrimination under Section 1557.

118. The Act stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress, including the objective of preventing discrimination in the provision of healthcare based on sex.

119. The Healthcare Provider Plaintiffs, Parent Plaintiffs, and Transgender Plaintiffs have no adequate remedy at law to redress the wrongs alleged herein, which are of a continuing nature and will cause them irreparable harm.

120. Accordingly, the Healthcare Provider Plaintiffs are entitled to declaratory and injunctive relief.

COUNT IV

Deprivation of Free Speech

All Plaintiffs Against Defendants in Their Official Capacities

U.S. Const. Amend. I

121. Plaintiffs incorporate all preceding paragraphs of the Complaint as if set forth fully herein.

122. All Plaintiffs bring this Count against all Defendants.

123. The Free Speech Clause of the First Amendment, enforceable pursuant to 42 U.S.C. § 1983, provides that “Congress shall make no law . . . abridging the freedom of speech.”

124. The First Amendment is applicable to the State of Alabama under the Fourteenth Amendment to the United States Constitution.

125. The Act creates an unlawful restriction on speech. By imposing criminal penalties on anyone who “cause[s]” any of the proscribed treatments to be performed on a minor, Defendants are punishing the Healthcare Provider Plaintiffs, the Parent Plaintiffs, and Reverend Eknes-Tucker for any speech that can be pointed to as resulting in a minor receiving any of the proscribed treatments – *e.g.*, referrals,

counseling, or discussions relating to well-established care recognized in the medical community as appropriate, safe treatment for gender dysphoria in transgender minors.

126. There is no constitutionally sufficient justification for the Act's restriction of speech. The Act is not rationally related to the furtherance of any legitimate government interest, let alone narrowly tailored to substantially advance any compelling or important government interest.

COUNT V

Deprivation of Procedural Due Process

All Plaintiffs Against Defendants in Their Official Capacities

Void for Vagueness

U.S. Const. Amend. V and XIV

127. Plaintiffs incorporate all preceding paragraphs of the Complaint as if set forth fully herein.

128. All Plaintiffs bring this Count against all Defendants.

129. Under the Due Process Clause, a criminal statute is void for vagueness if it either: (1) fails "to provide the kind of notice that will enable ordinary people to understand what conduct it prohibits" or (2) authorizes or encourages "arbitrary and discriminatory enforcement." *City of Chicago v. Morales*, 527 U.S. 41, 56 (1999).

130. Section 4(a) of the Act states, in relevant part, that "no person shall . . . cause any of the following practices to be performed upon a minor"

131. As written, the Act does not provide sufficient definiteness to ordinary people, including Plaintiffs, of what actions constitute “caus[ing]” any of the proscribed activities upon a minor.

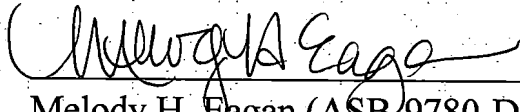
132. The lack of definiteness in the Act encourages arbitrary and discriminatory enforcement against anyone who is aware of, refers to, discusses, talks about, recommends, or gives an opinion on a transgender person’s healthcare.

RELIEF REQUESTED

WHEREFORE, Plaintiffs request that this Court:

- (1) issue a judgment, pursuant to 28 U.S.C. §§ 2201-2202, declaring that the Act violates federal law for the reasons and on the Counts set forth above;
- (2) temporarily, preliminarily, and permanently enjoin Defendants and their officers, employees, servants, agents, appointees, or successors from enforcing the Act;
- (3) declare that the Act violates the First, Fifth, and Fourteenth Amendments to the United States Constitution;
- (4) award Plaintiffs their costs and attorneys’ fees pursuant to 42 U.S.C. § 1988 and other applicable laws; and
- (5) grant such other relief as the Court finds just and proper.

Respectfully submitted this 19th day of April, 2022.



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DOC. 3

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

PAUL A. EKNES-TUCKER,
Rev., et al.,

Plaintiffs,

v.

KAY IVEY, *in her official capacity as*
Governor of the State of Alabama, et al.,

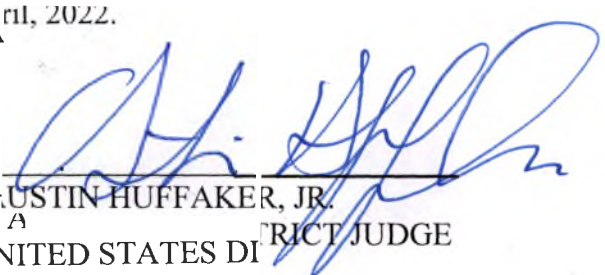
Defendants.

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) CASE NO. 2:22cv184-RAH-SRW
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ORDER

The Honorable Liles C. Burke, United States District Judge for the Northern District of Alabama, was previously assigned two cases substantially similar to the above-captioned case, both of which were voluntarily dismissed on April 15, 2022. By order of the Chief Judge of the United States Court of Appeals for the Eleventh Circuit, all United States District Judges in the State of Alabama may preside over cases in any of the State's three federal judicial districts. In accordance with that order, and by the authority of the Court to manage the district court docket, promote the orderly and expeditious disposition of cases, and reassign a case to a judge who presided over a prior-related case, this case is **REASSIGNED** to Judge Burke. Judge Burke shall sit by designation and preside over this case in the United States District Court for the Middle District of Alabama.

DOE, on this 20th day of April, 2022.


JUSTIN HUFFAKER, JR.
R. A.
UNITED STATES DISTRICT JUDGE

DOC. 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. 2:22-cv-184-
LCB

**PLAINTIFFS' MOTION FOR
A TEMPORARY
RESTRAINING ORDER
AND/OR PRELIMINARY
INJUNCTION**

**PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER
AND/OR PRELIMINARY INJUNCTION**

Plaintiffs Reverend 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. (collectively “Plaintiffs”), hereby move the Court pursuant to Rule 65 of the Federal Rules of Civil Procedure for preliminary injunctive relief and/or a temporary restraining order preventing the enforcement of Alabama’s Vulnerable Child Compassion and Protection Act (the “Act”), prior to its May 8, 2022 effective date. In addition, Plaintiffs respectfully request this Court exercise its discretion to waive the Federal Rule of Civil Procedure 65(c) security requirement. *BellSouth Telecomm., Inc. v. MCIMetro Access Transmission Servs., LLC*, 425 F.3d 964, 971 (11th Cir. 2005).

The Act makes it a Class C felony for any “person” to “engage in or cause” the performance of certain medical treatments on any 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 appearance or perception is inconsistent with the minor's sex as defined by [the] act.” This prohibition infringes upon the fundamental constitutional rights to parental autonomy and equal

protection, violates the right to freedom of speech, is void for vagueness, and conflicts with the Affordable Care Act.

First, the Act deprives parents of the fundamental right to obtain essential medical care for their children, in violation of the Fourteenth Amendment to the United States Constitution. Second, the Act violates the Equal Protection Clause of the Fourteenth Amendment by discriminating based on transgender status and sex. Third, the Act violates the First Amendment by criminalizing speech that would “cause” a transgender minor to receive medical treatment for gender dysphoria, thereby enacting a speech restriction that is not narrowly tailored to advance a compelling, or even legitimate, state interest. Fourth, the Act deprives Plaintiffs of due process and violates the Fifth and Fourteenth Amendments because 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). Fifth, the Act is preempted by Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116, because compliance with the Act would force covered health care providers to violate Section 1557.

As detailed more fully in the accompanying Memorandum of Law, Plaintiffs satisfy the requirements for preliminary injunctive relief and a temporary restraining order. *See McDonald’s Corp. v. Robertson*, 147 F.3d 1301, 1306 (11th Cir. 1998).

If the Act is not enjoined, Plaintiffs will suffer immediate and irreparable constitutional, medical, emotional, psychological, and other harm, for which there is no adequate remedy at law. The balance of hardships also favors Plaintiffs because a preliminary injunction and temporary restraining order would preserve the status quo; the harm imposed through enforcement of the felony health care ban is far greater than any harm that could result from the preliminary injunction or temporary restraining order. In addition, the entry of a preliminary injunction and/or temporary restraining order is in the public interest.

Accordingly, and for the reasons set forth in the accompanying Memorandum of Law, Plaintiffs respectfully request that this Motion for a Temporary Restraining Order and/or Preliminary Injunction be granted without security. *See City of Atlanta v. Metro. Atlanta Rapid Transit Auth.*, 636 F.2d 1084, 1094 (5th Cir. Unit B 1981) (recognizing “an exception to the Rule 65 security requirement” for “public-interest litigation”); *BellSouth*, 425 F.3d at 971 (citing *City of Atlanta* with approval).

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 Motion and accompanying Memorandum 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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DOC. 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.
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

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 medication 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.

/s/ Melody H. Eagan

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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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DOC. 8-1

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 adjusters.

Secured multiple internal and external 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, MEd, 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 2021 <https://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., Byner, 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 HBGDA) - 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 <i>**Human Rights Campaign Endorsed Training</i> 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 <i>**Human Rights Campaign Endorsed Training</i> 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

DOC. 8-2

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.

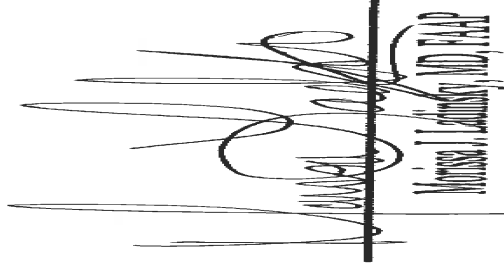
15. Puberty-blocking medication and hormone-replacement therapy have greatly improved the physical and mental health and wellbeing of my patients. Denying my patients access to these well-established medical treatments will cause the mental health of many of my patients to regress, including increasing 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 hereby make under penalty of perjury that the foregoing is true and correct.

20

Executed this 14 day of April, 2022.


Matthew J. Lonsky, MD, PhD

No. 22-11707

**UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT**

◆

PAUL A. EKNES-TUCKER, et al.,
Plaintiffs-Appellees,

&

UNITED STATES OF AMERICA
Intervenor-Plaintiff-Appellee,

v.

GOVERNOR OF THE STATE OF ALABAMA, et al.,
Defendants-Appellants.

◆

On Appeal from the United States District Court
for the Middle District of Alabama
Case No. 2:22-cv-184-LCB

APPELLANTS' APPENDIX VOLUME II OF XIII

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July 5, 2022

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Certificate of Service

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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, Feldman 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.

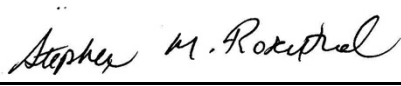
By: 
Stephen M. Rosenthal, M.D.

EXHIBIT A

University of California, San Francisco
CURRICULUM VITAE

Name: Stephen M Rosenthal, MD

Position: Recalled Faculty
 Pediatrics
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EDUCATION

1968 - 1972	Yale University	BA	Psychology
1972 - 1976	Columbia University, College 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 Society 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 Society 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 Conference 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 Conference 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 Endocrinology Fellowship Training 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 Endocrinology Fellowship Training 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 Francisco (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

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

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

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.

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.

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

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

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

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

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, Chulalongkorn U, Bangkok, Thailand
2009 - 2011	Jenise Wong, M.D., Ph.D.	Clinical Fellow, Pediatric Endocrinology		Clinical Preceptor	Instructor, UCSF

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

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

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 Chessner, 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 was published 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		\$ 325,000 direct/yr 1	\$ 1,625,000 total
Transgender Youth Support Program			
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		
2.	Principal investigator		
	Academic Senate Committee on Research, University of California San Francisco	1987	1988
	Insulin-like Growth Factors and Childhood Growth Disorders		
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		
4.	Principal Investigator		
	NIH/NICHD: Clinical Investigator Award	1988	1991
	Insulin-like Growth Factors and Childhood Growth Disorders		
5.	Principal Investigator		
	March of Dimes: Basil O'Connor Starter Scholar Research Award	1989	1992
	Insulin-like Growth Factors and Childhood Growth Disorders		
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.	Principal investigator		
	R01 DK44181		
	NIH/NIDDK	1998	2003
	IGFs and Skeletal Muscle Differentiation		\$ 659,648 total
12.	Co-Principal Investigator		
	HOE 9011/4030		
	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			

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OTHER PUBLICATIONS

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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 treatment 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, Cadnaphapornchai 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.

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

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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 phosphorylation 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 neuroblastoma 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.

DOC. 8-4

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

finances 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 17 th day of April, 2022.



Rev. Paul A. Eknes-Tucker

DOC. 8-5

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 away 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

DOC. 8-6

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

DOC. 8-7

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.

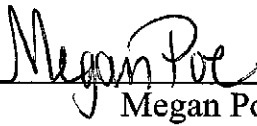
23. Without medical treatment all Allison's fears around developing an Adam's apple, facial hair, and other defining features of male puberty would become her reality. Her appearance would not align with who she is and would likely disclose to everyone that she is transgender, causing her extreme anxiety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

DOC. 8-8

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.

**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

DOC. 8-9

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.

**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.

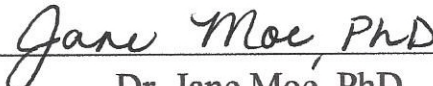
14. For me, the Act means that I would have to abandon my professional and ethical obligations when treating transgender patients or risk criminal penalty for providing mental health care consistent with the prevailing standards of care. I also will be prevented from educating my patients about treatment 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.



Dr. Jane Moe, PhD

DOC. 8-10

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.

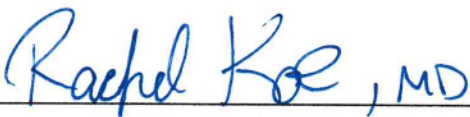
13. The Act places me in an impossible situation on multiple fronts. If I comply with the Act to avoid criminal penalties, I am abandoning my current transgender patient by not providing medical care consistent with the accepted standard of care. Further, as a medical provider who accepts Alabama Medicaid, 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.



Dr. Rachel Koe, MD

DOC. 20

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

REV. PAUL A. EKNES-TUCKER,	)	
et al.,	)	
	)	
<i>Plaintiffs,</i>	)	
	)	
v.	)	Civil Action No.:
	)	2:22-cv-184-LCB-SRW
KAY IVEY, in her official capacity	)	
as Governor of the State of Alabama,	)	
et al.,	)	
	)	
<i>Defendants.</i>	)	

**ANSWER OF DEFENDANTS STEVE MARSHALL, DARYL D. BAILEY, C. WILSON
BLAYLOCK, JESSICA VENTIERE, TOM ANDERSON, AND DANNY CARR**

Defendants Steve Marshall, sued in his official capacity as Attorney General for the State of Alabama, and District Attorneys Darryl D. Bailey, C. Wilson Blaylock, Jessica Ventiere, Tom Anderson, and Danny Carr, each sued in his or her official capacity, state as follows for their Answer to the Plaintiffs' Complaint:¹

1. Admitted.
2. Denied.
3. Admitted that the Act prohibits certain harmful treatments

administered "for the purpose of attempting to alter the appearance of or affirm the

¹ Defendant Kay Ivey, sued in her official capacity as Governor, will also be represented by the undersigned. She will respond separately to the Plaintiffs' Complaint.

minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex as defined in th[e] act." Denied that the Act "targets transgender minors" and denied that the proscribed treatments are "essential to the minors' health care needs."

4. Denied.

5. Admitted that Plaintiffs seek declaratory and injunctive relief to enjoin enforcement of the Act. Denied that they are entitled to any relief.

6. Denied that there are valid grounds for Plaintiffs to proceed anonymously. Otherwise, Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

7. Denied that there are valid grounds for Plaintiffs to proceed anonymously. Otherwise, Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

8. Denied that there are valid grounds for Plaintiffs to proceed anonymously. Otherwise, Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

9. Denied that there are valid grounds for Plaintiffs to proceed anonymously. Otherwise, Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

10. Denied that there are valid grounds for Plaintiffs to proceed anonymously. Otherwise, Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

11. Denied that there are valid grounds for Plaintiffs to proceed anonymously. Otherwise, Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

12. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

13. Admitted.

14. Admitted.

15. Admitted that Defendant Bailey is the District Attorney of Montgomery County with authority to prosecute criminal cases within the applicable judicial circuit.

16. Admitted that Defendant Blaylock is the District Attorney for the 32nd Judicial Circuit with authority to prosecute criminal cases within the circuit.

17. Admitted that Defendant Ventiere is the District Attorney for Lee County with authority to prosecute criminal cases within the applicable judicial circuit.

18. Admitted that Defendant Anderson is the District Attorney for the 12th Judicial Circuit with authority to prosecute criminal cases within the circuit.

19. Admitted that Defendant Carr is the District Attorney for Jefferson County, Alabama, with authority to prosecute criminal cases within the circuit.

20. Admitted that the Attorney General and District Attorneys have authority to enforce the Act. Denied that Governor Ivey possesses any authority to enforce the Act.

21. Admitted that Plaintiffs seek relief under the United States Constitution, the equitable powers of the Court, and a preemption claim related to Section 1557 of the Affordable Care Act. Denied that they are entitled to any relief.

22. Defendant does not contest personal jurisdiction.

23. Admitted that venue is proper in the Middle District of Alabama.

24. Denied.

25. Admitted that this Court has the authority to enter a declaratory judgment and provide equitable relief in a proper case. Denied that the Plaintiffs in this case are entitled to any relief.

26. Denied.

27. Denied.

28. Denied.

29. Denied.

30. Denied.

31. Admitted that WPATH has published purported “Standards of Care” for treatment of transgender people. Denied that WPATH is qualified to do so or that the resulting “Standards of Care” are based upon sound medical science.

32. Admitted that the Endocrine Society has promulgated a “guideline” for the provision of hormone therapy as a treatment of gender dysphoria in minors and adults. Denied that the “guideline” is based upon sound medical science.

33. Denied.

34. Denied that the described course of treatment generally reduces psychological distress of minors with gender dysphoria. Averred that the described course of treatment is experimental, harmful, and irreversible.

35. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

36. Denied.

37. Denied.

38. Denied.

39. Admitted.

40. Denied.

41. Admitted.

42. Admitted.

43. Denied.

44. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

45. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

46. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

47. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

48. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

49. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

50. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

51. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

52. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

53. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

54. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

55. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

56. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

57. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

58. Admitted that under the challenged Act, the described experimental, harmful, irreversible treatments will not be available to minors in Alabama if administered “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 appearance or perception is inconsistent with the minor’s sex as defined in th[e] act.” Denied that such treatments are essential to Plaintiff Zachary’s mental health, and denied that stopping such treatments will cause a person’s physical and mental health to suffer.

59. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

60. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

61. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

62. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

63. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

64. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

65. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

66. Admitted that under the challenged Act, the described experimental, harmful, irreversible treatments will not be available to minors in Alabama if administered “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 appearance or perception is inconsistent with the minor’s sex as defined in th[e] act.” Otherwise denied.

67. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

68. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

69. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

70. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

71. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

72. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

73. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

74. Denied.

75. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

76. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

77. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

78. Denied.

79. Denied.

80. Denied.

81. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

82. Denied that Dr. Moe's work with transgender patients is guided by "well-established standards of care." Otherwise, Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

83. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

84. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

85. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

86. Denied.

87. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

88. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

89. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

90. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

91. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

92. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

Count I

93. Defendants incorporate the foregoing paragraphs as if set forth fully herein.

94. Admitted.

95. The cases cited by Plaintiffs speak for themselves. Otherwise denied.

96. Denied.

97. Denied.

98. Denied.

Count II

99. Defendants incorporate the foregoing paragraphs as if set forth fully herein.

100. Admitted.

101. Admitted.

102. Denied.

103. Denied.

104. Denied.

105. Admitted that some classifications based on sex are subject to intermediate scrutiny. Denied that the Act discriminates on the basis of sex.

106. Denied.

107. Denied.

108. Denied.

109. Denied.

Count III

110. Defendants incorporate the foregoing paragraphs as if set forth fully herein.

111. Admitted.

112. The cited statute speaks for itself. Otherwise denied.

113. Denied.

114. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

115. Denied.

116. Defendants lack sufficient information to admit or deny the allegations in this paragraph, and therefore denies the same.

117. Denied.

118. Denied.

119. Denied.

120. Denied.

Count IV

121. Defendants incorporate the foregoing paragraphs as if set forth fully herein.

122. Admitted.

123. Admitted.

124. Admitted.

125. Denied.

126. Denied.

Count V

127. Defendants incorporate the foregoing paragraphs as if set forth fully herein.

128. Admitted.

129. The cited case speaks for itself.

130. Admitted that Plaintiffs have quoted a portion of the challenged Act.

131. Denied.

132. Denied.

Prayer for Relief

Defendants deny that Plaintiffs are entitled to any relief.

General Denial

Defendants deny each allegation in Plaintiffs' Complaint that is not expressly admitted above.

Additional Defenses

1. Defendants preserve the defense of sovereign immunity.
2. There is medical uncertainty concerning the proper treatment of gender dysphoria, and the Alabama Legislature has legal authority to regulate such treatment.
3. Plaintiffs have no private right of action under the Affordable Care Act.
4. The equities do not favor injunctive or declaratory relief.
5. The equities do not favor emergency injunctive relief.
6. Plaintiffs are not likely to prevail on the merits.
7. Plaintiffs have unclean hands.
8. One or more Plaintiffs lack standing to assert some or all of their claims.
9. Plaintiffs fail to state a claim on which relief may be granted.

10. Governor Ivey, who will file a separate motion to dismiss, did not cause any injury to Plaintiffs and cannot redress any alleged injury suffered by Plaintiffs.

Respectfully submitted,

Steve Marshall
Attorney General

/s/ James W. Davis
Edmund G. LaCour Jr. (ASB-9182-U81L)
Solicitor General
A. Barrett Bowdre (ASB-2087-K29V)
Deputy Solicitor General
James W. Davis (ASB-4063-I58J)
Deputy Attorney General
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***Counsel for Defendants Steve Marshall,
Daryl D. Bailey, C. Wilson Blaylock, Jessica
Ventiere, Tome Anderson, and Danny Carr***

CERTIFICATE OF SERVICE

I hereby certify that on April 21, 2022 I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to all counsel of record.

/s/ James W. Davis
*Counsel for Defendants Steve Marshall,
Daryl D. Bailey, C. Wilson Blaylock, Jessica
Ventiere, Tome Anderson, and Danny Carr*

DOC. 34

**UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION**

PAUL A. EKNES-TUCKER, <i>et al.</i>,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 2:22-cv-184-LCB
	)	
KAY IVEY, <i>et al.</i>,	)	
	)	
Defendants.	)	

ORDER

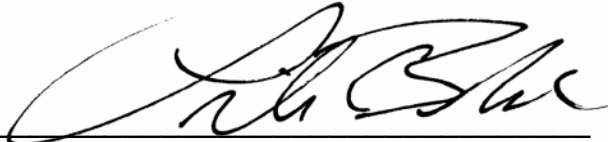
Upon consideration of Plaintiffs' motion to proceed pseudonymously (Doc. 6) and motion for a temporary restraining order and/or a preliminary injunction (Doc. 7), the Court ORDERS as follows:

An evidentiary hearing on Plaintiffs' motion for a temporary restraining order and/or a preliminary injunction is set for Thursday, May 5, 2022, at 9:00 a.m. CDT. The hearing is scheduled to last no longer than two days with the time allotted strictly as represented by the parties during today's status conference. The hearing will occur in Courtroom 2F of the Frank M. Johnson, Jr., United States Courthouse Complex. Forty-eight hours before the hearing begins, the parties shall file their proposed exhibits and a list of expected witnesses.

On or before April 27, 2022, Defendants shall file a response to Plaintiffs' motion to proceed pseudonymously. Plaintiffs' reply is due thirty-six hours after Defendants file their response.

On or before May 2, 2022, Defendants shall file a response to Plaintiffs' motion for a temporary restraining order and/or a preliminary injunction. Plaintiffs' reply is due thirty-six hours after Defendants file their response.

DONE and **ORDERED** April 22, 2022.



LILES C. BURKE
UNITED STATES DISTRICT JUDGE

DOC. 62

**IN THE 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,

and

UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

STATE OF ALABAMA; 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

Case No.

2:22-cv-184-LCB-SRW

Honorable Liles C. Burke

Opposed

the 12th Judicial Circuit; and DANNY CARR, in his official capacity as District Attorney for Jefferson County.

Defendants.

**PLAINTIFF-INTERVENOR UNITED STATES' MOTION FOR
TEMPORARY RESTRAINING ORDER AND
A PRELIMINARY INJUNCTION**

Plaintiff-Intervenor the United States of America (“United States”), pursuant to Rule 65 of the Federal Rules of Civil Procedure, hereby moves for a temporary restraining order and preliminary injunction to enjoin Defendants’ enforcement of Section 4 of Alabama Senate Bill (“S.B.”) 184. Counsel for the United States has spoken to counsel in the Alabama Attorney General’s Office, who indicated that the Defendants oppose the relief requested in this motion.

The felony ban on various forms of gender-affirming medical care for transgender minors contained in Section 4 of S.B. 184 discriminates on the basis of sex and transgender status in violation of the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution. The factual and legal bases for the United States’ motion are set forth in the accompanying Memorandum in Support of Plaintiff-Intervenor United States’ Motion for a Temporary Restraining Order and a Preliminary Injunction. The United States acknowledges that its Motion to Intervene [Dkt. No. 58], and Motion for Leave to

File Excess pages [Dkt. No. 60], are still pending and have not been ruled on by the Court [Dkt. No. 61].

In filing this motion, the United States does not seek to delay the case or the already-scheduled proceedings. The United States recognizes that S.B. 184 will go into effect on May 8, 2022 and that the *Eknes-Tucker* Plaintiffs previously filed a motion for a temporary restraining order and preliminary injunction, and that the Court has set a hearing on that motion, which is scheduled to begin on May 5, 2022. The United States' complaint in intervention and this motion do not raise any new claims and the government is prepared to argue and present evidence in support of this motion at the upcoming hearing, if permitted by the Court. The United States is also willing to forego filing a reply brief to prevent prejudice to the other parties.

Dated: April 29, 2022

Respectfully submitted,

SANDRA J. STEWART
United States Attorney
Middle District of Alabama

KRISTEN CLARKE
Assistant Attorney General
Civil Rights Division

PRIM F. ESCALONA
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s/Jason R. Cheek

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*Attorneys for Plaintiff-Intervenor United
States of America*

CERTIFICATE OF SERVICE

I hereby certify that on April 29, 2022, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to counsel of record.

Respectfully submitted,

s/ Jason R. Cheek

Jason R. Cheek

Assistant U.S. Attorney

DOC. 62-1

**IN THE 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,

and

UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

STATE OF ALABAMA; 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

Case No.

2:22-cv-184-LCB-SRW

Honorable Liles C. Burke

the 12th Judicial Circuit; and DANNY CARR, in his official capacity as District Attorney for Jefferson County.

Defendants.

MEMORANDUM IN SUPPORT OF PLAINTIFF-INTERVENOR UNITED STATES' MOTION FOR A TEMPORARY RESTRAINING ORDER AND A PRELIMINARY INJUNCTION

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MISCELLANEOUS

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INTRODUCTION

This lawsuit challenges a state statute that denies necessary medical care to children based solely on who they are. The “Alabama Vulnerable Child Compassion and Protection Act,” No. 2022-289, Senate Bill (“S.B.”) 184 (2022), conditions whether a minor can receive certain forms of medical care on the sex that young person was assigned at birth. Section 4 of S.B. 184 makes it a felony for any person to “engage in or cause” medically necessary gender-affirming procedures and treatments for transgender minors, while leaving other minors free to receive the same procedures and treatments.

By denying transgender minors—and only transgender minors—access to gender-affirming care, S.B. 184 violates the Equal Protection Clause of the Fourteenth Amendment. The law unjustifiably prohibits transgender minors from accessing medically necessary and appropriate care, while imposing no such limitation on cisgender minors. S.B. 184 discriminates on the basis of both sex and transgender status, and it fails intermediate scrutiny. The law’s ban on medically necessary gender-affirming care for transgender minors is not substantially related to serving an important government objective. To the contrary: the law actually harms the health of transgender youth. And it reflects a bias against transgender individuals that can never provide a legitimate basis for legislation. Indeed, S.B. 184 would not even survive rational-basis review.

Implementation of S.B. 184 will have immediate, drastic, and often traumatic physical and psychological impacts on vulnerable transgender children and will cause irreparable harm to medical professionals, parents and caregivers, transgender minors, and the interests of the United States. The balance of the equities and the public interest also justify preliminary relief. Therefore, the United States respectfully requests that this Court grant this motion.

BACKGROUND

I. Transgender Youth and Their Need for Medically Necessary and Appropriate Gender-Affirming Care

Transgender people are individuals whose gender identity does not conform with the sex they were assigned at birth. A transgender boy is a child or youth who was assigned a female sex at birth but whose gender identity is male; a transgender girl is a child or youth who was assigned a male sex at birth but whose gender identity is female. By contrast, a cisgender child has a gender identity that corresponds with the sex the child was assigned at birth. A person's gender identity is innate.

According to the American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders,¹ "gender dysphoria" is the diagnostic term for the condition experienced by some transgender people of clinically significant

¹ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, Text Revision (2022), <https://perma.cc/FM78-QMZ2>.

distress resulting from the lack of congruence between their gender identity and the sex assigned to them at birth. Declaration of Dr. Stephen Rosenthal, MD, in Support of Plaintiffs’ Motion for a Temporary Restraining Order & Preliminary Injunction, Dkt. 8-3 (“Rosenthal Decl.”) ¶¶ 24-25; Declaration of Dr. Linda A. Hawkins, Ph.D., LPC, in Support of Plaintiffs’ Motion for a Temporary Restraining Order & Preliminary Injunction, Dkt. 8-1 (“Hawkins Decl.”) ¶ 25.

To be diagnosed with gender dysphoria, the incongruence between sex assigned at birth and gender identity must persist for at least six months and be accompanied by clinically significant distress or impairment in occupational, social, or other important areas of functioning. Rosenthal Decl. ¶ 25. The inability of transgender youth to live consistent with their gender identity due to irreversible physical changes in their bodies has significant negative impacts on their overall health and well-being. *See* Hawkins Decl. ¶¶ 45-46. The delay or denial of medically necessary treatment for gender dysphoria causes many transgender minors to develop serious co-occurring mental health conditions, such as anxiety, depression, and suicidality. Rosenthal Decl. ¶¶ 26, 55; *see also* Hawkins Decl. ¶ 41.

Gender dysphoria is highly treatable with the use of medical treatments that address the clinically significant distress by helping people who are transgender live in alignment with their gender identity. *See* Rosenthal Decl. ¶¶ 23, 26. The

precise treatments for gender dysphoria depend on each person’s individualized needs. *Id.* ¶ 23; Hawkins Decl. ¶¶ 32-37. The types of treatments provided differ depending on the patient’s age. Rosenthal Decl. ¶ 33.

Medical treatment standards for gender dysphoria, including for minors, are well-established. Declaration of Dr. Armand Antommara in Support of Plaintiff-Intervenor United States’ Motion for a Temporary Restraining Order and a Preliminary Injunction (“Antommara Decl.”), attached hereto as Exhibit 1, ¶¶ 17, 23-38. The American Academy of Pediatrics agrees that gender-affirming care is safe, effective, and necessary for the health and wellbeing of minors suffering from gender dysphoria.² *Id.* ¶¶ 34-35. Before puberty, treatment for gender dysphoria does not include pharmaceutical or surgical intervention and is limited to “social transition.” Hawkins Decl. ¶ 27. Social transition refers to allowing a transgender child to live and express themselves in ways consistent with their gender identity. *See id.* ¶¶ 27-29.

The Endocrine Society’s clinical practice guidelines recognize that as transgender youth reach puberty, puberty-delaying hormone therapy may become medically necessary and appropriate. *See* Antommara Decl. ¶¶ 27, 35. This treatment allows transgender youth to avoid going through endogenous puberty

² Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, American Academy of Pediatrics Policy Statement (Oct. 1, 2018), <https://perma.cc/D4R6-GP6C>.

and the heightened gender dysphoria and permanent physical changes that puberty would cause. *See* Rosenthal Decl. ¶¶ 36-37. This treatment is not experimental: medications that delay the onset of puberty have been used for decades to treat early onset or “precocious puberty” for cisgender adolescents. Antommaria Decl. ¶¶ 23, 33.

Interventions such as prescribing puberty-blocking medication and hormone replacement therapy require substantial planning and consultation with medical and mental health providers. *See id.* ¶¶ 16, 42; Rosenthal Decl. ¶ 47. Under the Endocrine Society’s clinical guidelines, transgender adolescents may be eligible for puberty-blocking hormone therapy only if the following steps have been taken:

- A qualified mental health professional confirms the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria, gender dysphoria worsened with the onset of puberty, and any coexisting psychological, medical, or social problems that could interfere with treatment have been addressed, such that the patient’s situation and functioning are stable enough to start treatment;
- The adolescent has sufficient mental capacity to give informed consent to this treatment, has been informed of the effects and side effects of treatment (including potential loss of fertility) and options to preserve fertility; and has given informed consent and the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process; and
- A pediatric endocrinologist or other clinician experienced in pubertal assessment agrees with the indication for treatment, has confirmed that puberty has started in the adolescent, and has confirmed that there are no medical contraindications to treatment.

See Antommaria Decl. ¶¶ 41-42.³

For some transgender adolescents, it may also be medically necessary and appropriate to provide hormone therapy to initiate puberty consistent with their gender identity. *Id.* ¶¶ 28, 35. Evaluation for this treatment generally occurs starting around age 14; transgender adolescents are only eligible for hormone therapy if the steps above are satisfied. *Id.* ¶ 42. Under the World Professional Association for Transgender Health clinical guidelines, adolescents who are transgender may receive chest reconstructive surgery prior to the age of majority if they have severe gender dysphoria, provided they have been living consistent with their gender identity for a significant period of time. *See id.* ¶ 42. Other types of surgical interventions, including genital surgery, are not recommended until a patient has reached the age of majority. *Id.* ¶ 35.

II. The Legislative Debate Regarding Senate Bill 184

The process that produced S.B. 184 is replete with expressions of skepticism about and hostility to the needs of transgender youth. In 2021 statement, for example, Representative Wes Allen, a sponsor of S.B. 184, explained that a motivation behind legislation banning gender-affirming care for transgender youth

³ Wylie Hembree, Peggy Cohen-Kettenis, & Louis Gooren et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, *The Journal of Clinical Endocrinology & Metabolism* 3869-3903, Vol. 102, Issue 11 (Nov. 2017), <https://perma.cc/8R3P-6NQY>.

is to affirm that if children “are born male, that they’re a male and if they’re born female, they’re a female.”⁴

During legislative debates, proponents of S.B. 184, including Representative Allen⁵ and another bill sponsor, Senator Shay Shelnutt,⁶ referred to gender-affirming care, when provided to transgender youths as “child abuse” without explaining why gender-affirming care for all other youth is entirely appropriate.

Furthermore, during a March 2, 2022 House Judiciary Committee hearing held on Alabama House Bill 266 (a companion bill to S.B. 184), Representative Allen compared gender-affirming medical care to “vaping,” “dealing with cigarettes,” and “dealing with drinking”—each of them a form of voluntary activity that he characterized as antisocial.⁷ Representative Allen also compared prescribing medications in the context of gender-affirming care to giving “anabolic steroids” to young boys who believe they are a “Division I athlete” or a “professional athlete.”⁸ And later, during debate on April 7, 2022, Representative Allen not only analogized gender-affirming care to another often-criticized practice

⁴ Tony Perkins, *Wes Allen Discusses Upcoming Alabama Senate Vote on Vulnerable Child Compassion and Protection Act*, YouTube (Feb. 15, 2021), https://www.youtube.com/watch?v=E9Q_b22cUWw.

⁵ Alabama House Judiciary Committee, *House Judy Committee – 3/2/2022, 1:34:28 PM*, Vimeo (Mar. 2, 2022), <https://vimeo.com/683940881/4edaefda2>.

⁶ Kiara Alfonseca, *Alabama Governor Signs ‘Don’t Say Gay,’ Trans Care, and Bathroom Ban Bills*, ABC News (Apr. 8, 2022), <https://perma.cc/6ESP-A8E9>.

⁷ Alabama House Judiciary Committee, *supra* note 5.

⁸ *Id.*

but criticized parents who seek it for their children, stating, “We do not allow children to get tattoos even with parental permission. And why not? Because we do not allow parents to permanently alter the bodies of their children.”⁹ Even on its own terms, this statement is inaccurate; in fact, Alabama law does permit minors to obtain a tattoo with prior written informed consent of the parent or legal guardian. Ala. Code § 22-17A-2(a).

In signing S.B. 184 into law, Governor Kay Ivey also expressed moral disapproval of gender-affirming care for transgender youth: “I believe very strongly that if the Good Lord made you a boy, you are a boy, and if He made you a girl, you are a girl . . . [L]et us all focus on helping them to properly develop into the adults God intended them to be.”¹⁰

III. Senate Bill 184

Governor Ivey signed S.B. 184 into law on April 8, 2022. The law becomes effective on May 8, 2022. *See* S.B. 184, § 11.

Section 3 of the bill defines “sex” as the “biological state of being male or female, based on the individual’s sex organs, chromosomes, and endogenous hormone profiles.” *Id.* at § 3(3). S.B. 184’s legislative findings reject the need for interventions to treat gender dysphoria, describing such treatments as “unproven”

⁹ Alabama House of Representatives, *House Part 1 – 4/7/2022, 9:32:05 AM*, Vimeo (April 7, 2022), <https://vimeo.com/697000650/59a642f5d4>.

¹⁰ Alfonseca, *supra* note 6.

and “experimental” and causing “numerous harmful effects.” *Id.* at § 2(11). The findings characterize a “discordance between their sex and identity” as a phase that resolves itself over time in most cases. *Id.* at § 2(4)-(5).

Section 4 of S.B. 184 states that “no person shall engage in or cause” specified types of medical care to be performed on a minor¹¹ with “the purpose of attempting to alter the appearance of or affirm the minor’s perception of his or her gender or sex, if that appearance or perception is inconsistent” with their sex assigned at birth. *Id.* at § 4(a). The practices prohibited by Section 4 of S.B. 184 include administering puberty blockers, administering hormone therapy, and surgical interventions (including the removal of “any healthy or non-diseased body part or tissue, except for a male circumcision”). *Id.* at § 4(a)(1)-(6). Notably, there is an exception for procedures “undertaken to treat a minor born with a medically verifiable disorder of sex development.” *Id.* at § 4(b).

A violation of Section 4 of S.B. 184 is a Class C felony, *id.* at § 4(c), which is punishable by up to 10 years of imprisonment and a fine of up to \$15,000. *See* Ala. Crim. Code §§ 13-A-5-6(a)(3), 13A-5-11(a)(3).

By its very terms, Section 4 of S.B. 184 means that parents of transgender youth, transgender minors old enough to make their own medial decisions, health

¹¹ In Alabama, the age of majority is nineteen. Ala Crim. Code § 26-1-1(a).

care professionals, and others are forced to choose between forgoing medically necessary procedures and treatments or facing criminal prosecution.

ARGUMENT

For a court to issue a preliminary injunction, the plaintiff must establish the following: “(1) 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.” *United States v. Alabama*, 691 F.3d 1269, 1281 (11th Cir. 2012). Each of these factors is satisfied here.

I. The United States is Likely to Succeed on the Merits of its Equal Protection Claim

The United States is likely to succeed on the merits because Section 4 of S.B. 184 violates the Equal Protection Clause of the Fourteenth Amendment by discriminating against transgender minors on the basis of their sex and their membership in a quasi-suspect class. Not only does Section 4 fail the heightened scrutiny applicable to such laws; it would fail even rationality review.

A. S.B. 184’s Ban on Gender-Affirming Medical Care Warrants Heightened Scrutiny Under the Equal Protection Clause

Section 4 of S.B. 184 is subject to heightened scrutiny because, in forbidding transgender youth to obtain medically necessary gender-affirming care while

leaving all other minors eligible for such care, it discriminates on the basis of sex and transgender status.

1. S.B. 184's Ban on Gender-Affirming Care Discriminates on the Basis of Sex and Therefore Triggers Intermediate Scrutiny

S.B. 184 bans gender-affirming care only when that care is being provided to transgender individuals. As the Supreme Court instructed, treating an individual differently because that person is transgender “unavoidably” constitutes sex discrimination because it rests on a person’s having “one sex identified at birth” but identifying with a different sex or gender “today.” *Bostock v. Clayton County, Ga.*, 140 S. Ct. 1731, 1746 (2020). Similarly, the Eleventh Circuit has held that differential treatment based on “gender-nonconformity is sex discrimination, whether it’s described as being on the basis of sex or gender.” *Glenn v. Brumby*, 663 F.3d 1312, 1317 (11th Cir. 2011). Other circuits have held the same. *See Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 608-10 (4th Cir. 2020), *as amended* (Aug. 28, 2020); *Whitaker By Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1051 (7th Cir. 2017) (school policy requiring students to use bathroom in accordance with the sex on the student’s birth certificate “is inherently based upon a sex-classification”); *D.T. v. Christ*, 552 F. Supp. 3d 888, 896 (D. Ariz. 2021); *Flack v. Wisconsin Dep’t of Health Servs.*, 328 F. Supp. 3d 931, 948 (W.D. Wis. 2018).

Section 4 of S.B. 184 discriminates against transgender minors by

unjustifiably denying them access to certain forms of medically necessary care.

The law prohibits transgender minors from obtaining care that has been well established as medically appropriate and necessary, while imposing no comparable limitation on cisgender minors for obtaining the same forms of care.

In addition, Section 4 of S.B. 184 expressly discriminates on the basis of sex because the medical treatments available to an Alabama minor under S.B. 184 depend on the sex that minor was assigned at birth based on “the individual’s sex organs, chromosomes, and endogenous hormone profiles.” S.B. 184, § 3. Under S.B. 184, if a minor was assigned male at birth, that minor cannot receive any of the treatments or procedures identified in Section 4 that would “alter the appearance of” the minor in a way that is “inconsistent” with being male or that would “affirm” the minor’s “perception” of being female. *See* S.B. 184, § 4(a). Similarly, if a minor was assigned female at birth, that minor cannot receive any of the treatments or procedures identified in Section 4 that would “alter the appearance of” the minor in a way that is “inconsistent” with being female or that would “affirm” the minor’s “perception” of being male. *See id.* at § 4(a). By contrast, all other minors can access the covered treatments because those treatments are, for them, consistent with the sex the minor was assigned at birth. *See id.* at § 4(a). S.B. 184 also discriminates on the basis of sex because it conditions the availability of particular medical procedures on a sex stereotype:

that an individual's gender identity should match the sex that individual was assigned at birth. *See Glenn*, 663 F.3d at 1316, 1319-20; *see also United States v. Virginia*, 518 U.S. 515, 549-50 (1996).

Sex-based classifications like S.B. 184 are subject to heightened constitutional scrutiny, specifically intermediate scrutiny. *Virginia*, 518 U.S. at 555; *Glenn*, 663 F.3d at 1315-16 (citations and quotations omitted).

2. S.B. 184's Ban on Gender-Affirming Medical Care Discriminates Against Transgender Individuals, And Therefore Triggers Intermediate Scrutiny

S.B. 184 also warrants heightened scrutiny because it discriminates on the basis of transgender status. Its legislative findings reflect an intent to target transgender minors—and only transgender minors—by expressing a commitment to preventing medical care that addresses youth who experience “discordance between their sex and their internal sense of identity” and “reveal signs of gender nonconformity,” including those designated with “gender dysphoria.” *Compare* S.B. 184 § 2(2), 2(5), *with* Antommara Decl. ¶¶ 43-45.¹²

A law that criminalizes access to particular medical treatments based on

¹² It does not matter that S.B. 184 never expressly uses the word “transgender,” since it is clear beyond doubt that transgender minors are the focus on the bill. “Some activities may be such an irrational object of disfavor that, if they are targeted, and if they also happen to be engaged in exclusively or predominantly by a particular class of people, an intent to disfavor that class can readily be presumed.” *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 270 (1993); *see also Bostock*, 140 S. Ct. at 1741 (noting that it is “it is impossible to discriminate against a person for being . . . transgender without discriminating against that individual based on sex”); *Christ*, 552 F. Supp. 3d at 895-96.

individuals' transgender status demands heightened scrutiny because transgender people are a quasi-suspect class, as the two circuits to have squarely addressed the question have held. *See Grimm*, 972 F.3d at 611; *Karnoski v. Trump*, 926 F.3d 1180, 1200 (9th Cir. 2019). Several district courts have concluded the same.¹³

An analysis of the factors used by the Supreme Court confirms that classifications based on transgender status warrant heightened scrutiny.¹⁴ First, transgender people, as a class, have historically been subject to discrimination and continue to “face discrimination, harassment, and violence because of their gender identity.” *Whitaker*, 858 F.3d at 1051; *see also Grimm*, 972 F.3d at 611-12; *Flack*, 328 F. Supp. 3d at 953; *M.A.B.*, 286 F. Supp. 3d at 720; *Evancho*, 237 F. Supp. 3d at 288; *Highland*, 208 F. Supp. 3d at 874; *Adkins*, 143 F. Supp. 3d at 139.¹⁵

¹³ *See F.V. v. Barron*, 286 F. Supp. 3d 1131, 1145 (D. Idaho 2018), *decision clarified sub nom. F.V. v. Jeppesen*, 477 F. Supp. 3d 1144 (D. Idaho 2020); *Flack*, 328 F. Supp. 3d at 951-53; *M.A.B. v. Bd. of Educ. of Talbot Cnty.*, 286 F. Supp. 3d 704, 719 (D. Md. 2018); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 288 (W.D. Pa. 2017); *Bd. of Educ. of the Highland Loc. Sch. Dist. v. United States Dep't of Educ.*, 208 F. Supp. 3d 850, 873-74 (S.D. Ohio 2016); *Adkins v. City of New York*, 143 F. Supp. 3d 134, 139-140 (S.D.N.Y. 2015); *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015).

¹⁴ Those factors include whether the class (1) has historically been subjected to discrimination, *see Lyng v. Castillo*, 477 U.S. 635, 638 (1986); (2) has a defining characteristic that “frequently bears no relation to ability to perform or contribute to society,” *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 440-441 (1985); (3) has “obvious, immutable, or distinguishing characteristics that define them as a discrete group,” *Lyng*, 477 U.S. at 638; and (4) is a minority lacking political power, *Bowen v. Gilliard*, 483 U.S. 587, 602 (1987).

¹⁵ Ample evidence indicates that transgender people experience higher levels of physical and sexual violence, harassment, and discrimination in the workplace, housing, healthcare, and school than their non-transgender counterparts. Nearly half (47%) of respondents to the 2015 U.S. Transgender Survey reported being sexually assaulted. Sandy E. James et al., Nat'l Ctr. for Transgender Equal., *The Report of the 2015 U.S. Transgender Survey* (Dec. 2016), <https://perma.cc/5CL3-RG9E> (hereinafter USTS Report). Over 77% of respondents to the 2015

Second, no “data or argument suggest[s] that a transgender person, simply by virtue of transgender status, is any less productive than any other member of society.” *Adkins*, 143 F. Supp. 3d at 139.¹⁶ The American Psychiatric Association has concluded that “[b]eing transgender or gender diverse implies no impairment in judgment, stability, reliability, or general social or vocational capabilities.”¹⁷

Third, transgender individuals share “obvious, immutable, *or* distinguishing characteristics that define them as a discrete group.” *Bowen*, 483 U.S. at 602 (quoting *Lyng*, 477 U.S. at 638) (emphasis added). Specifically, transgender individuals’ “gender identity does not align with the gender they were assigned at birth.” *M.A.B.*, 286 F. Supp. 3d at 721. Multiple courts have held that transgender status is immutable, and “being transgender is not a choice[,] [r]ather, it is as natural and immutable as being cisgender.” *Grimm*, 972 F.3d at 612-613.¹⁸

Fourth, people who are transgender lack political power. *See id.* at 613. While the number of openly transgender elected officials is growing, they still

U.S. Transgender Survey who were out or perceived as transgender in kindergarten through twelfth grade reported having one or more negative experiences (such as verbal harassment or physical attacks) in K-12 because people thought they were transgender. *Id.* at 132, 133. Another recent study found 61% of employed transgender respondents between the ages of thirteen to twenty-four reported experiencing discrimination in the workplace. The Trevor Project, *Research Brief: LGBTQ Youth in the Workplace* (Mar. 30, 2021), <https://perma.cc/TG7W-E4J3>.

¹⁶ *Accord Grimm*, 972 F.3d at 612; *M.A.B.*, 286 F. Supp. 3d at 720; *Evancho*, 237 F. Supp. 3d at 288; *Highland*, 208 F. Supp. 3d at 874; *Norsworthy*, 87 F. Supp. 3d at 1119 n.8.

¹⁷ APA Assembly and Board of Trustees, *Position Statement on Discrimination Against Transgender and Gender Diverse Individuals* (2012, 2018), <https://perma.cc/ES7D-YVG2>.

¹⁸ *See also M.A.B.*, 286 F. Supp. 3d at 720-721; *Evancho*, 237 F. Supp. 3d at 288; *Highland*, 208 F. Supp. 3d at 874; *Norsworthy*, 87 F. Supp. 3d at 1119 n.8; *Adkins*, 143 F. Supp. 3d at 139-40.

represent a fraction of office holders. *Id.* The proliferation of enacted legislation aimed at restricting the rights of transgender individuals, particularly transgender minors, is further evidence of the limited political power of the transgender community.¹⁹

Because Section 4 of S.B. 184 discriminates against transgender persons and they constitute a quasi-suspect class, the statute is subject to intermediate scrutiny.

B. S.B. 184 Fails Heightened Scrutiny Because it is Not Substantially Related to Achieving Alabama’s Articulated Governmental Interests

To survive heightened scrutiny, the State must show that Section 4 of S.B. 184 “serves important governmental objectives” and that the “discriminatory means employed are substantially related to achievement of those objectives.” *See Virginia*, 518 U.S. at 524 (quoting *Mississippi Univ. for Women v. Hogan*, 458 U.S. 718, 724 (1982)); *see also Craig v. Boren*, 429 U.S. 190, 197 (1976). “The burden of justification is demanding and it rests entirely on the State.” *Virginia*, 518 U.S. at 533 (quoting *Mississippi Univ. for Women*, 458 U.S. at 724).

Heightened scrutiny requires that the justification proffered be “exceedingly

¹⁹ The very same day Governor Ivey signed S.B. 184 into law, she also signed H.B. 322 into law. Alfonseca, *supra* note 6. H.B. 322 requires students in public K-12 schools to only use bathrooms and locker rooms that correspond with the sex listed on their original birth certificate; it also bans classroom instruction regarding sexual orientation and gender identity that is not age or developmentally “appropriate.” Alabama has also issued Policy Order 63, which requires transgender individuals to undergo “gender reassignment surgery” before they may amend the sex designation on their driver’s licenses. *See Corbitt v. Taylor*, 513 F. Supp. 3d 1309 (M.D. Ala. 2021).

persuasive.” *Id.* at 531. The required inquiry provides an enhanced measure of protection in circumstances where there is a greater danger that the legal classification results from impermissible prejudice or stereotypes. *See City of Richmond v. J.A. Croson Co.*, 488 U.S. 469, 493 (1989) (plurality opinion).

Moreover, when intermediate scrutiny applies, the “justification must be genuine, not hypothesized or invented post hoc in response to litigation,” and “must not rely on overbroad generalizations.” *Virginia*, 518 U.S. at 533; *see also Glenn*, 663 F.3d at 1321; *SmithKline Beecham Corp. v. Abbott Labs.*, 740 F.3d 471, 482 (9th Cir. 2014) (noting that the court must examine the law’s “actual purposes and carefully consider the resulting inequality to ensure that our most fundamental institutions neither send nor reinforce messages of stigma or second-class status.”) (citing *United States v. Windsor*, 570 U.S. 744 (2013)). A classification does not withstand heightened scrutiny when “the alleged objective” of the classification differs from the “actual purpose.” *Mississippi Univ. for Women*, 458 U.S. at 730.

S.B. 184’s ban on medically necessary gender-affirming care for transgender youth does not survive the rigorous analysis that heightened scrutiny demands for two reasons. First, the State’s articulated objectives are pretextual justifications that mask the true purpose of the law: to express moral disapproval of a vulnerable and unpopular group. That desire is not legitimate, let alone important or

exceedingly persuasive. Second, even assuming the State’s asserted interest of protecting children is genuine, S.B. 184 is not substantially related to that interest because S.B. 184’s ban on various forms of gender-affirming care is harmful, not beneficial, to children.

1. Alabama’s Stated Interest of Protecting Children is Pretextual

S.B. 184’s stated purpose is to protect youth. The legislation’s text and its legislative history, however, belie the State’s stated purpose. “[I]f the constitutional conception of ‘equal protection of the laws’ means anything, it must at the very least mean” that the desire to express moral disapproval of “a politically unpopular group cannot constitute a legitimate governmental interest.” *Dep’t of Agriculture v. Moreno*, 413 U.S. 528, 534 (1973); *see also Palmore v. Sidoti*, 466 U.S. 429, 433 (1984). Unfortunately, S.B. 184’s real purpose is that forbidden desire.

The text and legislative history of S.B. 184 are marbled with expressions of moral disapproval of transgender status. So, too, its suggestion that transgender minors will “outgrow” their gender identity. S.B. 184, § 2(4).

Furthermore, S.B. 184’s legislative history, including statements from Governor Ivey and co-sponsor Representative Allen, *see pp. 7-8, supra*, reflect profound disapproval of people whose gender identity is inconsistent with the sex they were assigned at birth.

S.B. 184 bans particular treatments and procedures only when they are being

used to affirm a gender identity that is “inconsistent with the minor’s sex” as assigned at birth. S.B. 184, § 4. As such, S.B. 184 singles out transgender minors for discriminatory treatment. Those same procedures that S.B. 184 prohibits for transgender minors, remain as permissible as before for all other purposes, including gender-affirming care for anyone who is not transgender. Puberty blockers and surgical treatments can have “life implications,” S.B. 184, § 2(15), for cisgender and intersex minors too, and yet Alabama leaves the decisions whether to obtain such treatments to treating physicians, parents, and minors. The law’s selective concern undercuts the state’s profession of a legitimate purpose. *See Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 547 (1993) (a state undermines its stated interest “when it leaves appreciable damage to that supposedly vital interest unprohibited.”) (cleaned up).

2. S.B. 184 is Not Substantially Related to Protecting Children from “Harmful” Effects of Gender-Affirming Care

But even if the State’s asserted interest of protecting children were genuine, S.B. 184’s felony ban on certain forms of gender-affirming care would violate the Equal Protection Clause because the ban is not “substantially related” to achieving that objective. *Virginia*, 518 U.S. at 533 (quoting *Mississippi Univ. for Women*, 458 U.S. at 724) (internal quotations omitted). Quite the opposite: banning the forms of gender-affirming care criminalized by S.B. 184 will have devastating effects on many transgender youths while providing no countervailing benefit to

them or anyone else. *See Kirchberg v. Feenstra*, 609 F.2d 727, 734 (5th Cir. 1979) (courts must “weigh[] the state interest sought to be furthered against the character of the discrimination caused by the statutory classification”).

The empirical propositions upon which S.B. 184 rests are in fact untrue.

First, gender-affirming care for gender dysphoria is safe and effective.

Contrary to the State’s assertion that gender-affirming care for transgender youth has “numerous harmful effects,” *see* S.B. 184 § 11, the overwhelming weight of medical evidence confirms that the medical care that S.B. 184 forbids is safe, effective, and medically necessary treatment for the health and wellbeing of children and adolescents suffering from gender dysphoria. Antommaria Decl. ¶¶ 34-35; Rosenthal Decl. ¶¶ 23, 27-30; *see generally* pp. 4, 21-22, *supra*.²⁰

Moreover, delaying or denying gender-affirming care to transgender youth experiencing gender dysphoria can result in numerous harms, including depression, anxiety, and suicidality. *See* Hawkins Decl. ¶¶ 41, 45-46.²¹ The medical evidence shows that trying to “cure” a transgender individual with a gender dysphoria diagnosis by forcing them to live in alignment with their sex assigned at birth, and

²⁰ Rafferty, *supra* note 2.

²¹ *See* Dep’t of Health & Human Servs., Office of Population Affairs, *Gender Affirming Care and Young People*, at 1, <https://go.usa.gov/xuR8E> (“Medical and psychosocial gender affirming healthcare practices have been demonstrated to yield lower rates of adverse mental health outcomes, build self-esteem, and improve overall quality of life for transgender and gender diverse youth.”).

not their gender identity, is severely harmful and ineffective. *See* Antommara Decl. ¶ 47; Rosenthal Decl. ¶ 22.

Second, the medical research supporting gender-affirming care is substantial. Alabama is simply mistaken when it asserts that gender-affirming medical treatment for patients experiencing gender dysphoria is new, unproven, and poorly studied. *See* S.B. 184 § 2(11). To the contrary. Antommara Decl. ¶ 23. Leading medical associations, including the American Psychiatric Association, the World Professional Association for Transgender Health, the American Academy of Pediatrics, and the Endocrine Society, have all recognized that gender-affirming care is safe, effective, and medically necessary treatment for the health and wellbeing of some children and adolescents suffering from gender dysphoria. *Id.* ¶ 35. Hormone treatment for gender dysphoria began soon after estrogen and testosterone became commercially available in the 1930s and puberty blockers have been in use for over 20 years. *Id.* ¶ 23.

The assertions in S.B. 184’s legislative findings that the use of puberty blockers for youths experiencing gender dysphoria is “experimental” and not “FDA-approved,” *see* S.B. 184 § 2(7), is misleading. Antommara Decl. ¶¶ 17, 19. There have been ample observational studies, including federally funded trials, supporting the use of puberty blockers and other gender-affirming hormone therapy for adolescents. *Id.* ¶¶ 27-29.

The safety and effectiveness of the treatments and procedures used to treat minors experiencing gender dysphoria is not undermined because there have not been randomized, placebo-based trials for those treatments and procedures. *Id.* ¶¶ 24-30. And the absence of such trials does not render them “experimental.” *Id.* ¶¶ 14, 17, 23-30. In fact, such trials would be unethical because insufficient participants are likely to enroll, and investigators and participants cannot be “blind” since they would know if they were receiving the active treatment or a placebo due to changes in their bodies or the absence thereof. *Id.* ¶¶ 30-31. The lack of randomized trials is common for pediatrics. *Id.* ¶¶ 31-32. Relevant here, there is the same absence of randomized trials supporting the use of puberty blockers to treat precocious puberty (the premature initiation of puberty), *id.* ¶ 31, a practice Alabama law continues to permit. There is no medical or research basis for distinguishing the use of puberty blockers to treat precocious puberty from using them to treat gender dysphoria. *Id.* ¶¶ 3, 47.

Likewise, lack of FDA approval for a specific use does not bear on a treatment’s efficacy. FDA approval is not required for all uses of a medication and off-label use is in fact common in many areas of medicine, including pediatrics. *Id.* ¶¶ 20, 22. Once the FDA has approved a medication for one indication, thereby agreeing that it is safe (*i.e.*, its benefits outweigh its potential risks) and effective for this intended use, prescribers are generally free to prescribe it for other

indications. *Id.* ¶ 21. For example, nafcillin, an antibiotic commonly used to treat lung or joint infections, lacks a pediatric indication. *Id.* ¶ 22. There are many reasons, wholly unrelated to a drug’s safety or efficacy why its manufacturer might not seek FDA approval for an additional use or patient group; it may already be approved for adults but not for minors even though studies indicate it is safe when used by both groups. *Id.* ¶¶ 20 & n.2, 21.

Third, parents and many minors are able to comprehend the risks involved. S.B. 184’s legislative findings assert that minors and their parents “are unable to comprehend and fully appreciate the risk and life implications” of the treatments banned by Section 4. S.B. 184 § 2(15). This is incorrect. Antommara Decl. ¶ 39. To begin, parental consent is required before providing gender-affirming care to minors, as it is before medical providers render treatments with comparable risks, uncertainty, and levels of evidence. *Id.* ¶ 40. For example, the evidence indicates that most adolescents with gender dysphoria “have sufficient medical decision-making capacity to make decisions regarding puberty blockers.” *Id.* ¶ 41. And minors must be informed about all potential effects, including implications for fertility and options for fertility preservation, as a predicate step. *Id.* ¶ 42.

Moreover, S.B. 184 operates under the faulty presumption that parents, in consultation with their medical providers, cannot make reasoned, informed decisions about appropriate care for their children. In fact, parents “are frequently

asked to consent to medical treatments for minors with comparable risks, uncertainty, and levels of evidence.” *Id.* ¶¶ 40, 47. S.B. 184’s legislative findings offer no compelling reason why parents would be unable to do so only when these treatments are being provided to transgender youths.

Because the medical evidence demonstrates that S.B. 184’s prohibition on transgender youth who experience gender dysphoria receiving the specified forms of care when their physicians and parents agree that such care is appropriate simply does not substantially achieve the interest of protecting children, the statute violates the Equal Protection Clause. *See Feenstra*, 609 F.2d at 734.

3. S.B. 184’s Ban on Gender-Affirming Care Fails Even Rational Basis Review

Even if this Court were to apply only rational-basis review, S.B. 184’s ban on gender-affirming medical care could not survive. The ban lacks even a “rational relationship between the disparity of treatment and some legitimate governmental purpose.” *Heller v. Doe*, 509 U.S. 312, 320 (1993). By requiring that the “classification bear a rational relationship to an independent and legitimate legislative end,” courts ensure that “classifications are not drawn for the purpose of disadvantaging the group burdened by the law.” *Romer v. Evans*, 517 U.S. 620, 633 (1996).

As explained above, *see pp. 18-19, supra*, S.B. 184 in fact reflects a desire to express moral disapproval of transgender status. Given the law’s targeting of

transgender minors, its passage indeed “seems inexplicable by anything but animus toward” transgender people. *See id.* S.B. 184 is “a status-based enactment divorced from any factual context from which we could discern a relationship to legitimate state interests” *Romer*, 517 U.S. at 635. “[I]f the constitutional conception of ‘equal protection of the laws’ means anything, it must at the very least mean” that the desire to express moral disapproval of “a politically unpopular group cannot constitute a legitimate governmental interest.” *Moreno*, 413 U.S. at 534. S.B. 184 is motivated by prejudice toward a particular group, transgender individuals, bearing no rational relationship to the law’s stated purpose and thus cannot survive even the lowest level of review. *See Cleburne*, 473 U.S. at 450.

Thus, the United States is likely to succeed on the merits of its equal protection claim regardless of the level of scrutiny applied.

II. S.B. 184 Will Cause Irreparable Harm Absent an Injunction

If Section 4 of S.B. 184 is permitted to go into effect, the provision of certain types of medically necessary gender-affirming care to transgender minors will constitute a felony, punishable by up to 10 years in prison and a fine of up to \$15,000. S.B. 184 § 4(c); *see also* Ala. Crim. Code §§ 13-A-5-6(a)(3), 13A-5-11(a)(3). Courts have repeatedly recognized that the risk of criminal penalties constitutes an immediate and irreparable harm. *See, e.g., Georgia Latino All. for Hum. Rts. v. Deal*, 793 F. Supp. 2d 1317, 1340 (N.D. Ga. 2011), *aff’d in relevant*

part, Georgia Latino All. for Hum. Rts. v. Governor of Georgia, 691 F.3d 1250 (11th Cir. 2012); *Planned Parenthood Southeast, Inc. v. Bentley*, 951 F. Supp. 2d 1280, 1288-89 (N.D. Ala. 2013); *Cent. Alabama Fair Hous. Ctr. v. Magee*, No. 2:11-cv-982-MHT, 2011 WL 5878363, at *3 (M.D. Ala. Nov. 23, 2011).

That is especially true given the court of action S.B. 184 compels individuals to forgo. S.B. 184 will cause immense and irreparable physical and psychological harm to many transgender minors by terminating their access to necessary medical treatment and impose severe harm on their parents and medical providers. *See* Antommara Decl. ¶ 47; Hawkins Decl. ¶¶ 45-47; Rosenthal Decl. ¶¶ 56-57. As one district court explained, the following forms of irreparable harm can ensue: (1) transgender youths face “high risk of gender dysphoria and lifelong physical and emotional pain,” (2) parents must choose between watching their children suffer or uprooting their familiar to move to another state, and (3) physicians must choose between breaking the law and providing appropriate medical care. *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 892 (E.D. Ark. 2021); *see also Blaine v. North Brevard County Hospital District*, 312 F. Supp. 3d 1295, 1306 (M.D. Fla. 2018).²²

²² The Supreme Court and other courts have held that irreparable harm results from the enforcement of a state law that violates the Constitution. *See New Orleans Pub. Serv., Inc. v. Council of City of New Orleans*, 491 U.S. 350, 366-67 (1989) (assuming that irreparable injury may be established “by a showing that the challenged state statute is flagrantly and patently violative of . . . the express constitutional prescription of the Supremacy Clause”) (citation and internal quotation marks omitted); *United States v. Arizona*, 641 F.3d 339, 366 (9th Cir. 2011) (“We have ‘stated that an alleged constitutional infringement will often alone constitute

III. The Balance of the Equities and the Public Interest Both Weigh in the United States' Favor

The final two factors governing the issuance of preliminary relief—the balance of equities and the public interest—merge where the federal government is a party. *Nken v. Holder*, 556 U.S. 418, 435 (2009); *see also Pursuing Am. 's Greatness v. Fed. Election Comm'n*, 831 F.3d 500, 511 (D.C. Cir. 2016) (Government's "harm and the public interest are one and the same, because the government's interest is the public interest"). Here, these factors manifestly favor the United States. The United States has a strong and legitimate interest in ensuring that states respect their obligations under the Constitution, and in fulfilling the United States' responsibilities under Federal law.²³ If this Court does not grant preliminary relief, the lives of many transgender youth in Alabama and their families will be upended while the court continues to evaluate the lawfulness of S.B. 184 during the pendency of the litigation. *See Planned Parenthood Southeast, Inc.*, 951 F. Supp. 2d at 1290.

By contrast, Alabama will suffer no harm if the preliminary relief sought by the United States is granted; as discussed above, S.B. 184 fails to protect the health of minors notwithstanding its purported motivations. *See pp. 19-20, supra.*

irreparable harm.""); *see also City of El Cenizo v. Texas*, 264 F. Supp. 3d 744, 809 (W.D. Tex. 2017).

²³ *See* Letter from Kristen Clarke, Assistant Attorney General for Civil Rights, U.S. Dep't of Justice, to State Attorneys General (March 31, 2022), <https://go.usa.gov/xuR8w>.

Moreover, because the United States has demonstrated that it is likely to prevail on the merits, an injunction preventing the enforcement of the unconstitutional legislation poses no harm. *Alabama*, 691 F.3d at 1301 (“Frustration of federal statutes and prerogatives are not in the public interest, and we discern no harm from the state’s nonenforcement of invalid legislation.”); *KH Outdoor, LLC v. City of Trussville*, 458 F.3d 1261, 1271-72 (11th Cir. 2006) (“the city has no legitimate interest in enforcing an unconstitutional ordinance.”). In sum, the balance of the equities and the public interest weigh in the United States’ favor.

CONCLUSION

For the foregoing reasons, the Court should grant the United States’ motion for a temporary restraining order and a preliminary injunction.

Dated: April 29, 2022

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on April 29, 2022, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to counsel of record, in accordance with Rules 24(c) and 5(b)(2)(E).

Respectfully submitted,

s/ Jason R. Cheek

Jason R. Cheek

Assistant U.S. Attorney

No. 22-11707

**UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT**

◆

PAUL A. EKNES-TUCKER, et al.,
Plaintiffs-Appellees,

&

UNITED STATES OF AMERICA
Intervenor-Plaintiff-Appellee,

v.

GOVERNOR OF THE STATE OF ALABAMA, et al.,
Defendants-Appellants.

◆

On Appeal from the United States District Court
for the Middle District of Alabama
Case No. 2:22-cv-184-LCB

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July 5, 2022

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Certificate of Service

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EXHIBIT 1

Declaration of

Armand H. Antommara, MD, PhD, FAAP, HEC-C

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

REV. PAUL A. EKNES-TUCKER, et
al.,

Plaintiffs,

and

UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

KAY IVEY, in her official capacity as
Governor of Alabama, et al.

Defendants.

Case No. 2:22-cv-184-LCB-SRW

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

1. Counsel for the United States have retained me as an expert in connection with the above-captioned litigation.

2. 2022 Alabama Senate Bill 184 (SB 184) singles out for anomalous treatment certain medical interventions when these interventions are used for the purpose of gender transition, which I will refer to as gender-affirming medical care, criminalizing healthcare professionals who provide minors gender-affirming medical care or who refer minors for such care.

3. The legislative findings in SB 184 do not provide a sound medical or ethical basis for criminalizing the provision of gender-affirming medical care to minors with gender dysphoria nor could they because a sound medical or ethical basis for criminalizing such care does not exist.

4. I have actual knowledge of the matters stated in this declaration. In preparing this declaration, I reviewed the materials listed in the attached Bibliography (Exhibit A), as well as SB 184. I may rely on those documents as additional support for my opinions. I have also relied on my years of research and relevant experience, as set out in my curriculum vitae (Exhibit B), and on the materials listed therein. The materials I have relied upon in preparing this declaration are the same types of materials that experts in medicine and bioethics regularly rely upon when forming opinions on the subject. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications, or in response to statements and issues that may arise in my area of expertise.

BACKGROUND AND QUALIFICATIONS

5. I hold the following positions at Cincinnati Children's Hospital Medical Center: Director of the Ethics Center, Lee Ault Carter Chair of Pediatric Ethics, and Attending Physician in the Division of Hospital Medicine. I am also a

Professor in the Departments of Pediatrics and Surgery at the University of Cincinnati College of Medicine.

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

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

8. I have extensive experience as a practicing pediatrician. I have been in clinical practice since 2003 and approximately 30 percent of my current work is dedicated to caring for hospitalized patients.

9. I also have extensive experience as a bioethicist. Bioethicists examine the ethical issues that arise in medicine and the life sciences. I was Chair of the Ethics Committee at Primary Children's Medical Center in Salt Lake City, Utah from 2005 to 2012 and have been Director of the Ethics Center at Cincinnati Children's Hospital Medical Center since 2012. I consult on patients in the Transgender Health Clinic at Cincinnati Children's Hospital Medical Center whose

care presents unique ethical issues and participate in the Clinic's monthly multidisciplinary team meetings. I remain current with the medical and bioethics literature regarding the treatment of minors with gender dysphoria. I am also part of Cincinnati Children's Hospital Medical Center team that cares for patients born with intersex traits, also known as differences or disorders of sex development (DSD). I am also the Chair of Cincinnati Children's Hospital Medical Center Fetal Care Center's Oversight Committee, which provides the Center with recommendations regarding innovation and research.

10. I am a member of the American Academy of Pediatrics (AAP), the American Society for Bioethics and Humanities (ASBH), the Association of Bioethics Program Directors, and the Society for Pediatric Research. I was a member of the AAP's Committee on Bioethics from 2005 to 2011. I served as a member of the ASBH's Clinical Ethics Consultation Affairs Committee from 2009 to 2014 and currently serve on its Healthcare Ethics Consultant Certification Commission.

11. I am the author of 38 peer-reviewed journal articles, 11 non-peer-reviewed journal articles, 6 book chapters, and 26 commentaries. My peer-reviewed journal articles have been published in high-impact journals, including the *Journal of the American Medical Association* and *Annals of Internal Medicine*. I am also an

author of 17 policy statements and technical reports, including 4 as lead author, by the AAP.

12. I am a member of the Executive Editorial Board and the Associate Editor for Ethics Rounds of *Pediatrics*. *Pediatrics* is the AAP's flagship journal and Ethics Rounds is a type of article in which commentators analyze cases that raise ethical issues. I am an active peer reviewer for many medical journals, including the *American Journal of Bioethics* and the *Journal of Pediatrics*. I also review abstracts for meetings of professional organizations, including the Pediatric Academic Societies and ABSH. I was previously a member of the editorial boards of the *Journal of Clinical Ethics* and the *Journal of Medical Humanities*.

13. I have prepared declarations as an expert witness in the following cases involving the provision of gender-affirming medical care to adolescents with gender dysphoria: *Brant v. Rutledge*, Case No. 4:21CV450-JM (E.D. Ark.), *Doe v. Abbott*, No. D-1-GN-22-000977, 2022 WL 628912 (Tex. Dist. 353rd Judicial District, March 2, 2022), and *Walker v. Marshall*, No. 2:22-cv-167-ECM-SMD (M.D. Ala.). In *Doe v. Abbott*, I testified in court as an expert witness. I am being compensated at an hourly rate of \$250 per hour for preparation of expert declarations and reports, and \$400 per hour for time spent preparing for or giving deposition or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

GENDER-AFFIRMING MEDICAL CARE IS CLINICAL CARE

14. The SB 184 legislative findings claim that the use of gonadotrophin releasing hormone (GnRH) agonists, colloquially known as puberty blockers, to treat gender dysphoria¹ are experimental and not approved by the U.S. Food and Drug Administration (FDA). These claims are inaccurate and irrelevant, respectively.

15. Clinical practice and research are distinguished by their goals and methods. The goal of clinical practice is to benefit individual patients, and its method is individualized decision-making. The goal of research is to contribute to generalizable knowledge, and its method uses formal protocols that describe the research study's objectives and procedures. *See* National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. The Commission; 1978.

16. The clinical use of puberty blockers to treat gender dysphoria is not research or experimentation. The same is true for gender-affirming hormone treatment and mastectomies on transgender males (individuals assigned female at birth who identify as male) referred to at chest surgery. When administering these

¹ Gender dysphoria is “a marked incongruence between one’s experienced/expressed gender and their assigned gender” which is “associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.” American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. American Psychiatric Publishing; 2013.

treatments, clinicians seek to benefit individual patients and adjust the treatment based on individual patients' responses.

17. To the extent the legislative findings use the term “experimental” to convey an absence of evidence for gender affirming medical care, that suggestion is baseless. Gender affirming medical care is supported by clinical studies, evidence comparable to many other treatments in pediatrics, as detailed below.

18. SB 184 not only criminalizes gender-affirming medical care as clinical care, but also criminalizes the provision of these interventions as research. Such research is necessary, as it is in every area of medicine, to continue to advance treatment.

19. The suggestion that because puberty blockers and gender-affirming hormone treatment are not approved by the FDA for the treatment of gender dysphoria they are therefore experimental or unsafe is misleading. Off-label use of FDA-approved medications is legal, common, and often evidence-based.

20. FDA approval is not required for all uses of a medication. Once the FDA has approved a medication for one indication,² thereby agreeing that it is safe

² According to the FDA, an indication includes a number of factors: the particular disease or condition or the manifestation or symptoms of the disease or condition for which the drug is approved; whether the drug is approved for treatment, prevention, mitigation, cure, or diagnosis; and the population, including age group, for which the drug is safe and effective. Center for Drug Evaluation and Research and Center for Biologics Evaluation and Research, Food and Drug Administration,

(i.e., its benefits outweigh its potential risks) and effective for this intended use, as is the case with the medications at issue here, prescribers are generally free to prescribe it for other indications. U.S. Food & Drug Administration. Understanding unapproved use of approved drugs “off label.” February 5, 2018. Accessed March 23, 2022. <https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label>. The American Academy of Pediatrics (AAP) Committee on Drugs states, “[i]t is important to note that the term ‘off-label’ does not imply an improper, illegal, contraindicated, or investigational use” and “[t]he administration of an approved drug for a use that is not approved by the FDA is not considered research and does not warrant special consent or review if it is deemed to be in the individual patient’s best interest.”

21. The AAP Committee on Drugs further states “in no way does a lack of labeling signify that therapy is unsupported by clinical experience or data in children.” Frattarelli DA, Galinkin JL, Green TP, et al. Off-label use of drugs in

U.S. Department of Health and Human Services. Indications and Usage Section of Labeling for Human Prescription Drug and Biological Products—Content and Format: Guidance for Industry. July 2018. Accessed April 29, 2022. Available at <https://www.fda.gov/files/drugs/published/Indications-and-Usage-Section-of-Labeling-for-Human-Prescription-Drug-and-Biological-Products-%E2%80%9494-Content-and-Format-Guidance-for-Industry.pdf>. A medication approved for the treatment of asthma in adults would, for example, be prescribed off label if used to treat a different disease, like pneumonia, or a different age group, like children.

children. *Pediatrics*. 2014;133(3):563-567. Among the reasons for this is that, even if there is substantial evidence of safety and efficacy for a new indication, a sponsor may not seek FDA approval for it because doing so is not economically beneficial. Wittich CM, Burkle CM, Lanier WL. Ten common questions (and their answers) about off-label drug use. *Mayo Clin Proc*. 2012;87(10):982-990.

22. “Off-label” use of drugs is common in many areas of medicine, including pediatrics. For example, nafcillin, an antibiotic commonly used to treat children with invasive staphylococcal infections, such as lung or joint infections, lacks FDA approval in individuals under 18 years of age. *See* Nafcillin Injection, USP. February 2007. Accessed April 5, 2022. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2008/050655s017lbl.pdf. A recent study of children’s hospitals found that in 28.1% of encounters, at least one off-label drug was prescribed. *See* Yackey K, Stukus K, Cohen D, Kline D, Zhao S, Stanley R. Off-label medication prescribing patterns in pediatrics: An update. *Hosp Pediatr*. 2019;9(3):186-193. Examples of medications used off-label in this study included: albuterol, which is used to treat asthma; morphine, which is used to treat pain; and lansoprazole (Prevacid®), which is used to treat gastrointestinal reflux. The rate of off-label use may be significantly higher in certain age groups, categories of drugs, and clinical settings.

THE SAFETY AND EFFICACY OF GENDER-AFFIRMING MEDICAL CARE IS SUPPORTED BY EVIDENCE

23. The SB 184 legislative findings also incorrectly characterize gender-affirming medical treatment as new, unproven, and poorly studied. Gender-affirming medical care is not new. Hormone treatment for gender dysphoria began soon after estrogen and testosterone became commercially available in the 1930's. Stryker S. *Transgender History*. 2nd ed. Seal Press; 2017. The use of puberty blockers to treat gender dysphoria in adolescents, while more recent, is not new. The first reference to this treatment in the medical literature was in 1998, over twenty years ago. Cohen-Kettenis PT, van Goozen SH. Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent. *Eur Child Adolesc Psychiatry*. 1998;7(4):246-248. Prospective observational trials of puberty blockers began recruiting participants in 2000. de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *J Sex Med*. 2011;8(8):2276-2283

24. Gender-affirming medical care of adolescents with gender dysphoria is also neither poorly studied nor unproven. The major categories of studies used to evaluate innovative treatments are observational studies, which include cross-sectional and longitudinal studies, and randomized trials. In cross-sectional studies, investigators collect data at a single point in time. Cross-sectional design permits investigators to examine potential associations between factors, but it cannot prove

one factor caused the other. In longitudinal studies, researchers follow individuals over time, making continuous or repeated measures. In a randomized trial, participants are randomly assigned to a treatment or a comparison group. Neither the investigators nor the participants know to which group the participant is assigned. The major benefit of a randomized trial is that it decreases the likelihood that any differences in the outcomes between the groups is the result of baseline differences between the groups rather than the result of the intervention. Guyatt G, Rennie D, Meade MO, et al., eds. *Users' Guide to the Medical Literature: A Manual for Evidence-Based Clinical Practice*. 3rd ed. McGraw Hill Education; 2015; Perry-Parrish C, Dodge R. Research and statistics: Validity hierarchy for study design and study type. *Pediatr Rev*. 2010;31(1):27-29.

25. While randomized controlled trials are described in the medical literature as “high quality” evidence and observational studies as “low quality” evidence, randomized controlled trials may not be feasible or ethical, may have intrinsic methodological limitations, or may be unavailable in some contexts. “Low quality” evidence can be sufficient to justify treatment recommendations. *See* Swiglo BA, Murad MH, Schunemann HJ, et al. A case for clarity, consistency, and helpfulness: State-of-the-art clinical practice guidelines in endocrinology using the Grading of Recommendations, Assessment, Development, and Evaluation System. *J Clin Endocrinol Metab*. 2008;93(3):666-673. For example, the Endocrine Society

recommends that “clinicians prescribe and support the reduction of inactivity and also a minimum of 20 minutes of moderate to vigorous physical activity daily, with a goal of 60 minutes, all in the context of a calorie-controlled diet” to treat obesity. This recommendation is based on “low quality” evidence. Styne DM, Arslanian SA, Connor EL, et al. Pediatric obesity-assessment, treatment, and prevention: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2017;102(3):709-757.

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

27. The use of puberty blockers to treat gender dysphoria is supported by prospective observational trials including: Delemarre-van de Waal HA, Cohen-

Kettenis PT. Clinical management of gender identity disorder in adolescents: A protocol on psychological and pediatric endocrinology aspects. *Eur J Endocrinol.* 2006;155(suppl 1):S131–S137; de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *J Sex Med.* 2011;8(8):2276-2283; and de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics.* 2014;134(4):696-704.

28. Gender-affirming hormone therapy to treat gender dysphoria is also supported by prospective observational trials. These trials include de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics.* 2014;134(4):696-704.

29. There are also ongoing federally funded prospective observational trials of gender-affirming healthcare for adolescents with gender dysphoria in the U.S., trials that SB 184 would criminalize in Alabama. See National Institutes of Health RePORTER, The impact of early medical treatment in transgender youth. Accessed January 21, 2022.

<https://reporter.nih.gov/search/lGJnh68uokiic97N2X00kA/project->

[details/8965408](https://reporter.nih.gov/search/lGJnh68uokiic97N2X00kA/project-details/8965408); Olson-Kennedy J, Chan YM, Garofalo R, et al. Impact of early

medical treatment for transgender youth: Protocol for the longitudinal, observational trans youth care study. *JMIR Res Protoc*. 2019;8(7):e14434.

30. Under the applicable ethical standards, randomized, placebo-controlled trials (trials that compare pharmacological treatment to no pharmacological treatment) in gender dysphoria are currently unethical. Potential investigators do not have equipoise between pharmacological treatment and no pharmacological treatment; they believe that pharmacological treatment is superior. It is also highly unlikely that enough participants would enroll in randomized controlled trials for them to be informative. See Chew D, Anderson J, Williams K, May T, Pang K. Hormonal treatment in young people with gender dysphoria: A systematic review. *Pediatrics*. 2018;141(4):e20173742; Reisner SL, Deutsch MB, Bhasin S, et al. Advancing methods for US transgender health research. *Curr Opin Endocrinol Diabetes Obes*. 2016;23(2):198-207.

31. Even if randomized, placebo-controlled trials of gender-affirming health care were ethical, they would provide a lower quality of evidence because of intrinsic limitations in their design. For example, it would be impossible to “blind” the investigators or the participants to whether the participants were receiving the active treatment or a placebo. They would know if they were in the intervention or control arm of the study due to the physical changes in their bodies, or the lack thereof, over time. This might bias their perception of the outcomes. Atkins D, Best

D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490.

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

33. One directly relevant example of a widely accepted treatment based on prospective observational trials is the use of puberty blockers to treat central precocious puberty. Central precocious puberty is the premature initiation of puberty, before age 8 in people assigned female at birth and before age 9 in people assigned male, by the central nervous system. Its negative effects include impairment of final adult height as well as antisocial behavior and lower academic achievement. There are no randomized trials evaluating the adult height of treated and untreated individuals. Most studies are observational and compare pretreatment predicted and actual final height. These studies have additional limitations including

small sample sizes. This “low quality” evidence is nonetheless sufficiently strong to support the use of GnRH agonists as the standard of care for treatment of central precocious puberty. *See* Mul D, Hughes IA. The use of GnRH agonists in precocious puberty. *Eur J Endocrinol*. 2008;159(Suppl 1):S3-8.

34. Professional medical organizations develop evidence-based clinical practice guidelines to provide clinicians with helpful, evidence-based recommendations and improve patient care and outcomes. Organizations develop guidelines using systematic processes to select and review scientific evidence. Guidelines typically rate the quality of the evidence and grade the strength of recommendations. American Academy of Pediatrics Steering Committee on Quality Improvement and Management. Classifying recommendations for clinical practice guidelines. *Pediatrics*. 2004;114(3):874-877; Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations, *BMJ*. 2004;328(7454):1490.

35. The Endocrine Society, an international medical organization of over 18,000 endocrinology researchers and clinicians, has published a clinical practice guideline for the treatment of gender-dysphoric (GD)/gender-incongruent persons, which may include pubertal suppression, gender-affirming hormone therapy, and gender-affirming surgery. The guideline both rates the quality of the supporting evidence and grades the strength of its recommendations. It recommends both the

use of puberty blockers and gender-affirming hormone therapy to treat gender dysphoria in adolescents based on the best available evidence. The guideline recommends delaying gender-affirming genital surgery that removes the testicles, ovaries, and/or uterus until adulthood. *See* Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903; *see also* World Professional Organization for Transgender Health. *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People*, Version 7. World Professional Association for Transgender Health (WPATH); 2012.

36. Recommendations for pediatric care made by professional associations in guidelines are seldom based on well-designed and conducted randomized controlled trials due to their rarity and are frequently based on observational studies or, if such studies are unavailable, expert opinion. The medical use of the term “expert opinion” in this context differs from what I understand to be the use of this term in legal contexts. It refers to the consensus of experts in the field when studies are not available.

37. For example, none of the Endocrine Society’s 84 recommendations in two of its other guidelines that focus on the pediatric population—guidelines on pediatric obesity and congenital adrenal hyperplasia—is based on “high quality”

evidence. Twenty-four (29%) of the recommendations are based on “moderate,” and 49 (58%) on “low” or “very low quality” evidence. The remaining recommendations (11, 13%) are Ungraded Good Practice Statements. Table 1 (Exhibit C). See Speiser PW, Arlt W, Auchus RJ, et al. Congenital adrenal hyperplasia due to steroid 21-hydroxylase deficiency: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2018;103(11):4043-88; Styne DM, Arslanian SA, Connor EL, et al. Pediatric obesity-assessment, treatment, and prevention: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2017;102(3):709-757.

38. Guidelines issued by other professional associations concerning pediatric medical care are similar. For example, of the 130 recommendations in the American Heart Association’s guideline for Pediatric Basic and Advanced Life Support, only 1 (1%) is based on “high-quality evidence from more than 1 [randomized clinical trial]” and 3 (3%) on “moderate-quality evidence from 1 or more [randomized clinical trials].” The remainder of the recommendations were based on lower quality evidence. Topjian AA, Raymond TT, Atkins D, et al. Part 4: Pediatric basic and advanced life support: 2020 American Heart Association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care. *Circulation.* 2020;142(16_suppl_2):S469-S523. As reflected in medical professional associations’ guidelines, medical treatment in pediatrics is infrequently

based on “high” quality evidence and commonly based on lower quality evidence, including observational studies.

PARENTS AND LEGAL GUARDIANS ARE CAPABLE OF PROVIDING INFORMED CONSENT FOR GENDER-AFFIRMING MEDICAL CARE

39. SB 184 also incorrectly asserts that minors and their parents are unable to comprehend and fully appreciate the risks and life implications of gender-affirming health care.

40. First and foremost, parents or legal guardians generally must provide informed consent for medical treatment for minors, including gender-affirming medical care. There is no evidence cited in support of the assertion that parents of adolescents with gender dysphoria are unable to comprehend and fully appreciate the implications of gender-affirming medical care. Parents or legal guardians are frequently asked to consent to medical treatments for minors with comparable risks, uncertainty, or levels of evidence. Limitations in adults’ ability to predict what will contribute to satisfaction in the future, called affective forecasting, is not unique to decisions regarding gender-affirming medical care. And there are approaches healthcare providers use to improve affective forecasting. Wilson TD, Gilbert DT. Affective forecasting: Knowing what to want. *Curr Dir Psychol Sci*. 2005;14(3):131-134; Halpern J, Arnold RM. Affective forecasting: An unrecognized challenge in making serious health decisions. *J Gen Intern Med*. 2008;23(10):1708-1712.

41. Adolescents generally possess comparable medical decision-making capacity to adults. Louis A. Weithorn and Susan B. Campbell, for example, found that 14-year-olds performed similarly to adults with respect to their ability to understand and reason about treatment information. Weithorn LA, Campbell SB. The competency of children and adolescents to make informed treatment decisions. *Child Dev.* 1982;53(6):1589-1598. There is evidence that most adolescents with gender dysphoria have sufficient medical decision-making capacity to make decisions regarding puberty blockers. Vrouenraets L, de Vries ALC, de Vries MC, van der Miesen AIR, Hein IM. Assessing medical decision-making competence in transgender youth. *Pediatrics.* 2021;148(6): e2020049643. Similar to the aforementioned approaches to improve adult's affective forecasting, there are steps that healthcare providers take to promote adolescents' decision-making capacity. Katz AL, Webb SA, Committee on Bioethics. Informed consent in decision-making in pediatric practice. *Pediatrics.* 2016;138(2):e20161485.

42. The current standard of care for treating gender dysphoria in minors is consistent with general ethical principles instantiated in the practices of informed consent and shared decision-making. The Endocrine Society clinical practice guideline extensively discusses the potential benefits, risks, and alternatives to gender-affirming medical care, and its recommendations regarding the timing of interventions are based in part on the treatment's potential risks and the adolescent's

decision-making capacity. The guideline recommends that informed consent for pubertal blockers and gender-affirming hormones include a discussion of the implications for fertility and options for fertility preservation. The Endocrine Society clinical guideline also advises delaying gender-affirming hormone treatment, which results in partly irreversible physical changes until an adolescent has developed sufficient medical decision-making capacity. The guideline states clinicians should individualize decision-making for breast or chest surgery in transgender males and that chest surgery may be considered in individuals under 18 years old. *See* Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2017;102(11):3869-3903.

SB 184 SINGLES OUT GENDER-AFFIRMING MEDICAL CARE FOR ANOMALOUS TREATMENT

43. SB 184's legislative findings do not provide a sufficient basis for criminalizing and singling out for anomalous treatment the provision of gender-affirming healthcare to adolescents with gender dysphoria. For example, as previously mentioned, SB 184 permits the use of puberty blockers to treat central precocious puberty, but criminalizes the use of puberty blockers to treat gender dysphoria, even though using puberty blockers in connection with both conditions has comparable risks and is supported by comparable types of evidence.

44. Additionally, while SB 184 would prohibit chest surgery on transgender males, minors are permitted to undergo many comparable surgeries, such as those for gynecomastia, pectus excavatum or carinatum, and breast reconstruction. Gynecomastia is the proliferation of ductal or glandular breast tissue, as opposed to adipose tissue or fat, in individuals whose sex assigned at birth is male. Pectus excavatum and carinatum are chest wall anomalies in which the sternum is depressed or protrudes, respectively. While surgeries to treat these conditions, as well as breast reduction and augmentation for individuals whose sex assigned at birth and gender identity are female, may at times be performed to lessen physical symptoms, such as pain or exercise intolerance, they are commonly performed to reduce psychosocial distress. Gynecomastia and breast augmentation surgery affirm patients' gender identity, that is, to respectively help someone assigned male at birth feel more typically masculine and someone assigned female at birth feel more typically feminine. Risks of these procedures include bleeding, infection, scarring and poor cosmetic outcome, loss of sensation, and impaired breast/chest feeding. Some surgeries have unique risks such as catastrophic perforations of the heart or lungs in some forms of pectus repair, or capsule formation around a breast implant causing hardening and pain. *See Buziashvili D, Gopman JM, Weissler H, et al. An evidence-based approach to management of pectus excavatum and carinatum. Ann Plast Surg. 2019;82(3):352-358; Nordt CA,*

DiVasta AD. Gynecomastia in adolescents. *Curr Opin Pediatr*. 2008;20(4):375-382;
Zuckerman D, Abraham A. Teenagers and cosmetic surgery: Focus on breast augmentation and liposuction. *J Adolesc Health*. 2008;43(4):318-324.

45. As these examples of chest surgeries in adolescents illustrate, surgeries for minors can require weighing short- and long-term effects, benefits, and risks in the face of uncertainty. Individual needs shape these evaluations and, therefore, the adolescents' participation is essential. There is nothing unique about chest surgery for gender dysphoria that justifies singling out this and other medical treatments for gender dysphoria for a criminal prohibition based on a concern for adolescents' inability to assent or parents or guardians' inability to consent. As with other medical decisions for adolescents, medical decisions regarding treatment for gender dysphoria should continue to be left to the discretion of transgender adolescents, their parents or guardians, and their healthcare providers.

46. Ironically, while SB 184 criminalizes gender-affirming medical care for youth with gender dysphoria in the name of protecting vulnerable children, the statute expressly allows doctors to perform irreversible surgeries on infants and children with intersex conditions or differences or disorders of sex development (DSD) at ages when they are unable to meaningfully participate in medical decision making. Such surgeries are highly controversial when performed at such an early age and can result in life-long complications and side effects. *See* Frader J, Alderson

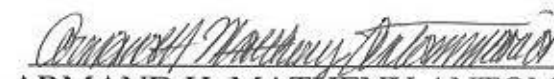
P, Asch A, et al. Health care professionals and intersex conditions, *Arch Pediatr Adolesc Med.* 2004;158(5):426-428.

CONCLUSIONS

47. The Endocrine Society's recommendations for treating adolescents with gender dysphoria with pubertal suppression, gender-affirming hormones, and chest surgery are well within the range of other decisions that adolescents and their parents or guardians in Alabama have the discretion to make. Based on my research and experience as a pediatrician and bioethicist, there is no sound medical or ethical basis to criminalize this care. Doing so puts clinicians in the untenable position of having to either follow state law and knowingly harm their patients, or face penalties including imprisonment and loss of their medical licenses.

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

Executed: April 29, 2022



ARMAND H. MATHENY ANTOMMARIA, MD, PhD

EXHIBIT A

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Zuckerman D, Abraham A. Teenagers and cosmetic surgery: Focus on breast augmentation and liposuction. *J Adolesc Health*. 2008;43(4):318-324.

EXHIBIT B

Curriculum Vitae

Last Updated: March 22, 2022

PERSONAL DATA

Armand H. Matheny Antommara, MD, PhD, FAAP, HEC-C
Birth Place: Pittsburgh, Pennsylvania
Citizenship: United States of America

CONTACT INFORMATION

Address: 3333 Burnet Ave, ML 15006, Cincinnati, OH 45229
Telephone Number: (513) 636-4939
Electronic Mail Address: armand.antommara@cchmc.org

EDUCATION

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

BOARD CERTIFICATION

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

PROFESSIONAL LICENSES

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

PROFESSIONAL EXPERIENCE

Full Time Positions

2019-Present *Professor*
Cincinnati Children's Hospital Medical Center, Cincinnati, OH
Department of Surgery
2019-Present *Professor of Clinical-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Surgery
2017-Present *Professor*
Cincinnati Children's Hospital Medical Center, Cincinnati, OH

2017-Present	Division of Pediatric Hospital Medicine <i>Professor of Clinical-Affiliated</i> University of Cincinnati, Cincinnati, OH Department of Pediatrics
2016-2017	<i>Associate Professor of Clinical-Affiliated</i> University of Cincinnati, Cincinnati, OH Department of Pediatrics
2012-2017	<i>Associate Professor</i> Cincinnati Children's Hospital Medical Center, Cincinnati, OH Division of Pediatric Hospital Medicine
2012-Present	<i>Lee Ault Carter Chair in Pediatric Ethics</i> Cincinnati Children's Hospital Medical Center
2012-2016	<i>Associate Professor-Affiliated</i> University of Cincinnati, Cincinnati, OH Department of Pediatrics
2010-2012	<i>Associate Professor of Pediatrics (with Tenure)</i> University of Utah School of Medicine, Salt Lake City, UT Divisions of Inpatient Medicine and Medical Ethics
2010-2012	<i>Adjunct Associate Professor of Medicine</i> University of Utah School of Medicine, Salt Lake City, UT Division of Medical Ethics and Humanities
2004-2010	<i>Assistant Professor of Pediatrics (Tenure Track)</i> University of Utah School of Medicine, Salt Lake City, UT Divisions of Inpatient Medicine and Medical Ethics
2004-2010	<i>Adjunct Assistant Professor of Medicine</i> University of Utah School of Medicine, Salt Lake City, UT Division of Medical Ethics and Humanities
2003-2004	<i>Instructor of Pediatrics (Clinical Track)</i> University of Utah School of Medicine, Salt Lake City, UT Divisions of Inpatient Medicine and Medical Ethics
2003-2004	<i>Adjunct Instructor of Medicine</i> University of Utah School of Medicine, Salt Lake City, UT Division of Medical Ethics

Part Time Positions

2021	<i>Consultant</i> Proctor & Gamble, Cincinnati, OH
2019	<i>Consultant</i> Sanofi Genzyme, Cambridge, MA
2018-Present	<i>Consultant</i> Center for Conflict Resolution in Healthcare, Memphis, TN
2017-2020	<i>Consultant</i> Amicus Therapeutics, Cranbury, NJ

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

2017 *Consultant*
Sarepta Therapeutics, Cambridge, MA

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

Editorial Experience

Editorial Board

2020-Present *Pediatrics*, Associate Editor for Ethics Rounds and Member of the Executive Editorial
Board

2015-2020 *Journal of Clinical Ethics*

2009-2020 *Journal of Medical Humanities*

Guest Academic Editor

2017 *PLOS|ONE*

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

SCHOLASTIC AND PROFESSIONAL HONORS

2021 *Hidden Gem Award*, Cincinnati Children's Hospital Medical Center, Cincinnati, OH

2019-2021 *Presidential Citation*, American Society for Bioethics and Humanities, Chicago, IL

2016 *Laura Mirkinson, MD, FAAP Lecturer*, Section on Hospital Medicine, American Academy of Pediatrics, Elk Grove Village, IL

2016, 2018 *Certificate of Excellence*, American Society for Bioethics and Humanities, Glenview, IL

2013, 2016 *Senior Resident Division Teaching Award*, Cincinnati Children's Hospital Medical Center, Cincinnati, OH

2012 *Role Model*, Quality Review Committee, Primary Children's Medical Center, Salt Lake City, UT

2011 *Member*, Society for Pediatric Research, The Woodlands, TX

2011 *Presidential Citation*, American Society for Bioethics and Humanities, Glenview, IL

2009 *Role Model*, Quality Review Committee, Primary Children's Medical Center, Salt Lake City, UT

2008 *Nominee*, Physician of the Year, Primary Children's Medical Center, Salt Lake City, UT

2005-2006 *Fellow*, Medical Scholars Program, University of Utah School of Medicine, Salt Lake City, UT

1995-1997 *Doctoral Scholar*, Crossroads, A Program of Evangelicals for Social Action, Philadelphia PA
1989-1992 *Fellow*, The Pew Program in Medicine, Arts, and the Social Sciences, University of Chicago, Chicago, IL

ADMINISTRATIVE EXPERIENCE

Administrative Duties

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

Professional & Scientific Committees

Committees

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

Data Safety and Monitoring Boards

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

Reviewer

2020-Present *Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting
2020 *Grant Reviewer*, The Croatian Science Foundation, Hrvatska zaklada za znanost (HRZZ)
2018 *Book Proposal Reviewer*, Elsevier
2018-2019 *Category Leader*, Religion, Culture, and Social Sciences, American Society for Bioethics and Humanities Annual Meeting
2017 *Timekeeper*, American Society for Bioethics and Humanities Annual Meeting
2017-Present *Abstract Reviewer*, Pediatric Academic Societies Annual Meeting
2016-2021 *Workshop Reviewer*, Pediatric Academic Societies Annual Meeting
2016 *Grant Reviewer*, Innovation Research Incentives Scheme, The Netherlands Organisation for Health Research and Development
2016-2017 *Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting
2014, 2016 *External Peer Reviewer*, PSI Foundation, Toronto, Ontario, Canada
2014 *Member*, Scientific Committee, International Conference on Clinical Ethics and Consultation
2013 *Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting
2013 *Reviewer*, Open Research Area Plus, Agence Nationale de la Recherche, Deutsche Forschungsgemeinschaft, Economic and Social Research Council, National Science Foundation, and Organization for Scientific Research
2011-2012 *Abstract Reviewer*, Pediatric Academic Societies Annual Meeting
2011-2013 *Workshop Reviewer*, Pediatric Academic Societies Annual Meeting
2011-2014 *Abstract Reviewer*, Pediatric Hospital Medicine Annual Meeting
2011-2012 *Religious Studies Subcommittee Leader*, Program Committee, American Society for Bioethics and Humanities Annual Meeting
2010 *Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting

Other

2021 *Timekeeper*, American Society for Bioethics and Humanities Annual Meeting
2021 *Mentor*, Early Career Advisor Professional Development Track, American Society for Bioethics and Humanities.
2021 *Mentor*, Early Career Advisor Paper or Project Track, American Society for Bioethics and Humanities.
2109 *Mentor*, Early Career Advising Program, American Society for Bioethics and Humanities
2018 *Passing Point Determination*, Healthcare Ethics Consultant-Certified Examination, Healthcare Ethics Consultant Certification Commission
2018 *Member*, Examination Committee, Healthcare Ethics Consultant-Certified Examination, Healthcare Ethics Consultant Certification Commission
2018 *Item Writer*, Healthcare Ethics Consultant-Certified Examination, Healthcare Ethics Consultant Certification Commission

UNIVERSITY COMMUNITY ACTIVITIES

Cincinnati Children's Hospital Medical Center

2020-Present *Member*, Faculty Diversity and Inclusion Steering Committee
2020-Present *Member*, Medical Management of COVID-19 Committee
2020-2021 *Member*, Caregiver Refusal Team
2020-2021 *Member*, COVID-19 Vaccine Allocation Committee
2020 *Member*, Personal Protective Equipment Subcommittee of the COVID-19 Steering Committee
2018-2019 *Member*, Planning Committee, Center for Clinical & Translational Science & Training Research Ethics Conference
2017-Present *Member*, Donor Selection Committee
2017-2020 *Member*, Employee Emergency Fund Review Committee
2017 *Member*, Root Cause Analysis Team
2016-2017 *Member*, Planning Committee, Center for Clinical & Translational Science & Training Research Ethics Conference
2015-2019 *Member*, Destination Excellence Medical Advisory Committee
2015-Present *Member*, Disorders of Sexual Development Case Review Committee
2015-2019 *Member*, Destination Excellence Case Review Committee
2014-2018 *Member*, Genomics Review Group, Institutional Review Board
2014-2017 *Member*, Center for Pediatric Genomics Leadership Committee
2013-2017 *Member*, Genetic Testing Subcommittee, Health Network
2013-2016 *Member*, Schwartz Center Rounds Planning Committee
2013-2014 *Member*, Genomics Ad Hoc Subcommittee, Board of Directors
2012-Present *Member*, Cincinnati Fetal Center Oversight Committee
2012-Present *Member*, Ethics Committee
2012-Present *Member*, G-23
2012-2016 *Member*, Integrated Solid Organ Transplant Steering Committee

University of Utah

2009-2012 *Member*, Consolidated Hearing Committee

University of Utah School of Medicine

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

University of Utah Department of Pediatrics

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

Intermountain Healthcare

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

Primary Children's Medical Center

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

ACTIVE MEMBERSHIPS IN PROFESSIONAL SOCIETIES

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

FUNDING

Past Grants

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

2015-2016 "Ethics of Informed Consent for Youth in Foster Care"
Direct Costs: \$10,000
Ethics Grant, Center for Clinical and Translational Science and Training
University of Cincinnati Academic Health Center
Role: Co-Investigator

2014-2015 "Extreme Personal Exposure Biomarker Levels: Engaging Community Physicians and Ethicists for Guidance"
Direct Costs: \$11,640
Center for Environmental Genetics
University of Cincinnati College of Medicine
Role: Investigator

2014-2015 "Child, Adolescent, and Parent Opinions on Disclosure Policies for Incidental Findings in Clinical Whole Exome Sequencing"
Direct Costs: \$4,434
Ethics Grant, Center for Clinical and Translational Science and Training, University of Cincinnati Academic Health Center
Role: Principal Investigator

2013-2014 "Better Outcomes for Children: GWAS & PheWAS in eMERGEII
Percent Effort: 5%
National Human Genome Research Institute
Grant Number: 3U01HG006828-0251
Role: Investigator

2004-2005 "Potential Patients' Knowledge, Attitudes, and Beliefs Regarding Participating in Medical Education: Can They be Interpreted in Terms of Presumed Consent?"
Direct Costs: \$8,000

Interdisciplinary Research in Applied Ethics and Human Values, University Research
Committee, University of Utah
Role: Principal Investigator

TEACHING RESPONSIBILITIES/ASSIGNMENTS

Course and Curriculum Development

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

Course Lectures

2018, 2021 Introduction to Biotechnology, “Ethics and Biotechnology” and “Clinical Ethics,” BIOL
3027, University of Cincinnati, Taught 1 time per year, Taken by undergraduate students,
Enrollment 25.

2018-Present Biomedical Ethics, “Conscientious Objection in Healthcare” and “Ethical Issues in the
Care of Transgender Adolescents,” MEDS 4035 & MEDS 4036, University of Cincinnati
College of Medicine, Taught 1 time per year, Taken by senior undergraduate students,
Enrollment 52.

2016 Foundations of Healthcare Ethics and Law, “Clinical Ethics,” HESA 390, Xavier
University.

2014-Present Physicians and Society, “Transfusion and the Jehovah’s Witness Faith,” “Obesity
Management: Ethics, Policy, and Physician Implicit Bias,” “Embryos and Ethics: The
Ethics of Designer Babies,” “Ethics and Genetic Testing,” and “Ethics and Direct to
Consumer Genetic Testing,” 26950112 and 26950116, University of Cincinnati School of
Medicine, Taken by first and second year medical students, Enrollment 100.

2014-Present Ethical Issues in Health Care, “Ethical Issues in Managing Drug Shortages: The Macro,
Meso, and Micro Levels,” HESA 583, College of Social Sciences, Health, and Education
Health Services Administration, Xavier University, Taken by health services
administration students, Enrollment 25.

2009 Physical Diagnosis II, Internal Medicine 7160, University of Utah School of Medicine,
Taught 1 time per year, Taken by medical students, Enrollment 100

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

Small Group Teaching

2018-Present Ethics in Research, GNTD 7003-001, University of Cincinnati School of Medicine,
Taught 1 time per year, Taken by fellows, MS, and PhD students, Enrollment 110.

2007 Physical Diagnosis I, Internal Medicine 7150, University of Utah School of Medicine,
Taught 1 time per year, Taken by medical students, Enrollment 100

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

2003 Pediatric Organ System, Pediatrics 7020, University of Utah School of Medicine, Taught
1 time per year, Taken by medical students, Enrollment 100

Graduate Student Committees

2018-Present *Chair*, Scholarship Oversight Committee, William Sveen, Pediatric Critical Care
Fellowship, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH

2018-2020 *Member*, Scholarship Oversight Committee, Anne Heueman, Genetic Counseling,
University of Cincinnati, Cincinnati, OH

2017-2019 *Chair*, Scholarship Oversight Committee, Bryana Rivers, Genetic Counseling, University
of Cincinnati, Cincinnati, OH

- 2013-2015 *Mentor*, Sophia Hufnagel, Combined Pediatrics/Genetics Residency, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
- 2013-2015 *Co-Chair*, Scholarship Oversight Committee, Andrea Murad, Genetic Counseling, University of Cincinnati, Cincinnati, OH
- 2013-2014 *Member*, Scholarship Oversight Committee, Grace Tran, Genetic Counseling, University of Cincinnati, Cincinnati, OH
- 2011-2012 *Chair*, Scholarship Oversight Committee, Kevin E. Nelson, MD, PhD, Pediatric Inpatient Medicine Fellowship, University of Utah, Salt Lake City, UT

Continuing Education Lectures

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

Other Educational Activities

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

PEER-REVIEWED JOURNAL ARTICLES

1. Anne C Heuerman, Danielle Bessett, Armand H. Matheny Antommara, Leandra. K. Tolusso, Nicki Smith, Alison H. Norris and Michelle L. McGowan (2021). "Experiences of reproductive genetic counselors with abortion regulations in Ohio." *Journal of Genetic Counseling*. Online ahead of print. PMID: 34755409.
2. Armand H. Matheny Antommara and Ndidi I. Unaka. (2021) "Counterpoint: Prioritizing Health Care Workers for Scarce Critical Care Resources is Impractical and Unjust." *Journal of Hospital Medicine*. 16: 182-3. PMID 33617445.
3. Gregory A. Grabowski, Armand H. Matheny Antommara, Edwin H. Kolodny, and Pramod K. Mistry. (2021) "Gaucher Disease: Basic and Translational Science Needs for More Complete Therapy and Management." *Molecular Genetics and Metabolism*. 132: 59-75. PMID: 33419694.
4. Armand H. Matheny Antommara, Laura Monhollen, and Joshua K. Schaffzin. (2021) "An Ethical Analysis of Hospital Visitor Restrictions and Masking Requirements During the COVID-19." *Journal of Clinical Ethics*. 32(1): 35-44. PMID 33416516.
5. Armand H. Matheny Antommara (2020) "The Pediatric Hospital Medicine Core Competencies: 4.05 Ethics." *Journal of Hospital Medicine*. 15(S1): 120-121.
6. Armand H. Matheny Antommara, Tyler S. Gibb, Amy L. McGuire, Paul Root Wolpe, Matthew K. Wynia, Megan K. Applewhite, Arthur Caplan, Douglas S. Diekema, D. Micah Hester, Lisa Soleymani Lehmann, Renee McLeod-Sordjan, Tamar Schiff, Holly K. Tabor, Sarah E. Wieten, and Jason T. Eberl for a Task Force of the Association of Bioethics Program Directors (2020) "Ventilator

- Triage Policies During the COVID-19 Pandemic at U.S. Hospitals Associated With Members of the Association of Bioethics Program Directors.” *Annals of Internal Medicine*. 173(3): 188-194. PMID: 32330224.
7. Armand H. Matheny Antommara (2020) “Conflicting Duties and Reciprocal Obligations During a Pandemic.” *Journal of Hospital Medicine*. 5:284-286. PMID: 32379030.
8. Mary V. Greiner, Sarah J. Beal, and Armand H. Matheny Antommara (2020) “Perspectives on Informed Consent Practices for Minimal-Risk Research Involving Foster Youth.” *Pediatrics*. 45:e20192845. PMID: 32156772.
9. Jennifer deSante-Bertkau, Michelle McGowan, and Armand H. Matheny Antommara (2018) “Systematic Review of Typologies Used to Characterize Clinical Ethics Consultations.” *Journal of Clinical Ethics*. 29:291-304. PMID: 30605439.
10. Andrew J. Redmann, Melissa Schopper, Armand H. Matheny Antommara, Judith Ragsdale, Alessandro de Alarcon, Michael J. Jutter, Catherine K. Hart, and Charles M. Myer. (2018) “To Transfuse or Not to Transfuse? Jehovah’s Witnesses and PostOperative Hemorrhage in Pediatric Otolaryngology.” *International Journal of Pediatric Otorhinolaryngology*. 115:188-192. PMID: 30368384.
11. Armand H. Matheny Antommara, Kyle B. Brothers, John A. Myers, Yana B Feygin, Sharon A. Aufox, Murray H. Brilliant, Pat Conway, Stephanie M. Fullerton, Nanibaa’ A. Garrison, Carol R. Horowitz, Gail P. Jarvik, Rongling Li, Evette J. Ludman, Catherine A. McCarty, Jennifer B. McCormick, Nathaniel D. Mercaldo, Melanie F. Myers, Saskia C. Sanderson, Martha J. Shrubsole, Jonathan S. Schildcrout, Janet L. Williams, Maureen E. Smith, Ellen Wright Clayton, Ingrid A. Holm. (2018) “Parents’ Attitudes toward Consent and Data Sharing in Biobanks: A Multi-Site Experimental Survey.” *AJOB Empirical Research*. 21:1-15. PMID: 30240342.
12. Armand H. Matheny Antommara and Cynthia A. Prows. (2018) “Content Analysis of Requests for Religious Exemptions from a Mandatory Influenza Vaccination Program for Healthcare Personnel” *Journal of Medical Ethics*. 44: 389-391. PMID: 29463693.
13. Armand H. Matheny Antommara (2017) “May Medical Centers Give Nonresident Patients Priority in Scheduling Outpatient Follow-Up Appointments?” *Journal of Clinical Ethics*. 28: 217-221. PMID: 28930708.
14. Andrea M. Murad, Melanie F. Myers, Susan D. Thompson, Rachel Fisher, and Armand H. Matheny Antommara (2017) “A Qualitative Study of Adolescents’ Understanding of Biobanks and Their Attitudes Toward Participation, Re-contact, and Data Sharing.” *American Journal of Medical Genetics: Part A*. 173: 930-937. PMID: 28328120.
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Book Reviews

1. Armand H. Matheny Antommara (2021) Review of *When Harry Became Sally: Responding to the Transgender Moment*, by Ryan T. Anderson. *Journal of Medical Humanities* 42: 195-9. PMID 31808021.
2. Armand H. Matheny Antommara (2012) Review of *The Ethics of Organ Transplantation*, by Steven J. Jensen, ed., *Journal of the American Medical Association* 308: 1482-3.
3. Armand H Matheny Antommara (2012) Review of *The Soul of Medicine: Spiritual Perspectives and Clinical Practice*, by John R. Peteet and Michael N. D'Ambra, ed., *Journal of the American Medical Association* 308: 87.
4. Armand H. Matheny Antommara (2009) Review of *Conflicts of Conscience in Health Care: An Institutional Compromise*, by Holly Fernandez Lynch. *American Journal of Bioethics* 9: 63-4.
5. Armand H. Matheny Antommara (2008) Review of *A Practical Guide to Clinical Ethics Consulting: Expertise, Ethos, and Power*, by Christopher Meyers. *American Journal of Bioethics* 8: 72-3.
6. Armand H. Matheny Antommara (2004) Review of *Children, Ethics, and Modern Medicine*, by Richard B. Miller. *American Journal of Bioethics* 4: 127-8.
7. Armand H. Matheny Antommara (2002) Review of *Ward Ethics: Dilemmas for Medical Students and Doctors in Training*, by Thomasine Kushner and David Thomasma, ed. *American Journal of Bioethics* 2: 70-1. PMID: 22494193.
8. Armand H. Matheny Antommara (1999) Review of *Human Cloning: Religious Responses*, by Ronald Cole-Turner, ed. *Prism* 6 (March/April): 21.
9. Armand H. Matheny Antommara (1999) Review of *Christian Theology and Medical Ethics: Four Contemporary Approaches*, by James B. Tubbs, Jr. *Journal of Religion* 79 (April): 333-5.
10. Armand H. Matheny Antommara (1997) Review of *Body, Soul, and Bioethics*, by Gilbert C. Meilaender. *Prism* 4 (May/June): 28.

Newspaper Articles

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

UNPUBLISHED POSTER PRESENTATIONS

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

ORAL PRESENTATIONS

Keynote/Plenary Lectures

International

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

National

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

14. 2008, *Invited Conference Faulty*, Conscience and Clinical Practice: Medical Ethics in the Face of Moral Controversy, The MacLean Center for Clinical Medical Ethics at the University of Chicago, “Defending Positions or Identifying Interests: The Uses of Ethical Argumentation in the Debate over Conscience in Clinical Practice,” Chicago, IL, March 18.
15. 2007, *Symposium Speaker*, Alternative Dispute Resolution Strategies in End-of-Life Decisions, The Ohio State University Mortiz College of Law, “The Representation of Children in Disputes at the End-of-Life,” Columbus, Ohio, January 18.
16. 2005, *Keynote Speaker*, Decisions and Families, *Journal of Law and Family Studies* and The University of Utah S.J. Quinney College of Law, “Jehovah’s Witnesses, Roman Catholicism, and Calvinism: Religion and State Intervention in Parental, Medical Decision-Making,” Salt Lake City, Utah, September 23.

Regional/Local

1. 2021, *Panelist*, Pediatric Residency Noon Conference, University of Tennessee Health Science Center, “Bioethics Rounds—Ethical Issues in the Care of Transgender Adolescents,” Memphis, Tennessee, September 21.
2. 2020, *Keynote Speaker*, 53rd Annual Clinical Advances in Pediatrics, “Referral to a Fetal Care Center: How You Can Help Patients’ Mothers Address the Ethical Issues,” Kansas City, Kansas, September 16.
3. 2019, *Speaker*, Patient and Family Support Services, Primary Children’s Hospital, “Ethical Issues in the Care of Trans Adolescents,” Salt Lake City, Utah, December 5.
4. 2019, *Speaker*, Evening Ethics, Program in Medical Ethics and Humanities, University of Utah School of Medicine, “Patients, Parents, and Professionals: Ethical Issues in the Treatment of Trans Adolescents,” Salt Lake City, Utah, December 4.
5. 2019, *Speaker*, Pediatric Hospital Medicine Board Review Course, “Ethics, Legal Issues, and Human Rights including Ethics in Research,” Cincinnati, Ohio, September 8.
6. 2019, *Speaker*, Advances in Fetology, “Evolving Attitudes Toward the Treatment of Children with Trisomies,” Cincinnati, Ohio, September 6.
7. 2019, *Speaker*, Half-Day Ethics Training: Ethics Consultation & Ethics Committees, “Navigating the Rapids of Clinical Ethics Consultation: Intake, Recommendations, and Documentation,” Salt Lake City, Utah, June 1.
8. 2019, *Speaker*, Scientific and Ethical Underpinnings of Gene Transfer/Therapy in Vulnerable Populations: Considerations Supporting Novel Treatments, BioNJ, “What Next? An Ethical analysis of Prioritizing Conditions and Populations for Developing Novel Therapies,” Cranbury, New Jersey, March 7.
9. 2018, *Panelist*, Periviability, 17th Annual Regional Perinatal Summit, Cincinnati, Ohio, October 12.
10. 2018, *Speaker*, Regional Advance Practice Registered Nurse (APRN) Conference, “Adults are Not Large Children: Ethical Issues in Caring for Adults in Children’s Hospitals,” Cincinnati, Ohio, April 26.
11. 2018, *Speaker*, Southern Ohio/Northern Kentucky Sigma Theta Tau International Annual Conference, “Between Hope and Hype: Ethical Issues in Precision Medicine,” Sharonville, Ohio, March 2.
12. 2017, *Speaker*, Advances in Fetology 2017, “Ethics of Innovation and Research: Special Considerations in Fetal Therapy Centers,” Cincinnati, Ohio, October 27.
13. 2016, *Speaker*, End-of-Life Pediatric Palliative Care Regional Conference, “Ethical/Legal Issues in Pediatric Palliative Care,” Cincinnati, Ohio, September 15.
14. 2016, *Speaker*, 26th Annual Bioethics Network of Ohio (BENO) Conference, “When Does Parental Refusal of Medical Treatment for Religious Reasons Constitute Neglect?” Dublin, Ohio, May 29.
15. 2014, *Speaker*, Cincinnati Comprehensive Sickle Cell Center Symposium: Research Ethics of Hydroxyurea Therapy for Sickle Cell Disease During Pregnancy and Lactation, “Ethical Issues in Research with Pregnant and Lactating Women,” Cincinnati, Ohio, October 30.

16. 2014, *Speaker*, Advances in Fetology 2014, "The 'Miracle Baby' and Other Cases for Discussion," Cincinnati, Ohio, September 26.
17. 2014, *Speaker*, Advances in Fetology 2014, "'Can you tell me ...?': Achieving Informed Consent Given the Prevalence of Low Health Literacy," Cincinnati, Ohio, September 26.
18. 2014, *Panelist*, Center for Clinical & Translational Science & Training, Secrets of the Dead: The Ethics of Sharing their Data, Cincinnati, Ohio, August 28.
19. 2014, *Speaker*, Office for Human Research Protections Research Community Forum: Clinical Research ... and All That Regulatory Jazz, "Research Results and Incidental Findings: Do Investigators Have a Duty to Return Results to Participants," Cincinnati, Ohio, May 21.
20. 2013, *Opening Presentation*, Empirical Bioethics: Emerging Trends for the 21st Century, University of Cincinnati Center for Clinical & Translational Science & Training, "Empirical vs. Normative Ethics: A Comparison of Methods," Cincinnati, Ohio, February 21.
21. 2012, *Videoconference*, New York State Task Force on Life and the Law, "Pediatric Critical Care Triage," New York, New York, March 1.
22. 2011, *Presenter*, Fall Faculty Development Workshop, College of Social Work, University of Utah, "Teaching Ethics to Students in the Professions," Salt Lake City, Utah, November 14.
23. 2011, *Speaker*, 15th Annual Conference, Utah Chapter of the National Association of Pediatric Nurse Practitioners, "Ethical Issues in Pediatric Practice," Salt Lake City, Utah, September 22.
24. 2011, *Speaker*, Code Silver! Active Shooter in the Hospital, Utah Hospitals & Health Systems Association, Salt Lake City, Utah, March 21.
25. 2009, *Speaker*, Medical Staff Leadership Conference, Intermountain Healthcare, "The Ethics of Leadership," Park City, Utah, October 30.
26. 2008, *Speaker*, The Art and Medicine of Caring: Supporting Hope for Children and Families, Primary Children's Medical Center, "Medically Provided Hydration and Nutrition: Ethical Considerations," Salt Lake City, Utah, February 25.
27. 2005, *Speaker*, Utah NAPNAP (National Association of Pediatric Nurse Practitioners) Chapter Pharmacology and Pediatric Conference, "Immunization Update," Salt Lake City, Utah, August 18.
28. 2005, *Keynote Speaker*, 17th Annual Conference, Utah Society for Social Work Leadership in Health Care, "Brain Death: Accommodation and Consultation," Salt Lake City, March 18.
29. 2004, *Continuing Education Presentation*, Utah NAPNAP (National Association of Pediatric Nurse Practitioners), "Febrile Seizures," Salt Lake City, Utah, April 22.
30. 2004, *Speaker*, Advocacy Workshop for Primary Care Providers, "Ethics of Advocacy," Park City, Utah, April 3.
31. 2002, *Speaker*, 16th Annual Biologic Basis of Pediatric Practice Symposium, "Stem Cells: Religious Perspectives," Deer Valley, Utah, September 14.

Meeting Presentations

International

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

National

1. 2021, *Panelist*, Pediatric Endocrine Society Annual Meeting, Difference of Sex Development Special Interest Group, Virtual Conference, April 29.
2. 2020, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Is This Child Dead? Controversies Regarding the Neurological Criteria for Death,” Virtual Conference, October 17.
3. 2020, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Contemporary Ethical Controversy in Fetal Therapy: Innovation, Research, Access, and Justice,” Virtual Conference, October 15.
4. 2020, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “K-12 Schools and Mandatory Public Health Programs During the COVID-19 Pandemic,” Virtual Conference, October 15.
5. 2019, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Ethical Issues in Translating Gene Transfer Studies Involving Children with Neurodegenerative Disorders,” Pittsburgh, Pennsylvania, October 26.
6. 2019, *Moderator*, Pediatric Academic Societies Annual Meeting, Clinical Bioethics, Baltimore, Maryland, April 28.
7. 2018, *Presenter*, American Society for Bioethics and Humanities Annual Meeting, “Looking to the Past, Understanding the Present, and Imaging the Future of Bioethics and Medical Humanities’ Engagement with Transgender Health,” Anaheim, California, October 19.
8. 2018, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Should Vaccination Be a Prerequisite for Solid Organ Transplantation?” Anaheim, California, October 18.
9. 2018, Lindsey Douglas, Armand H. Matheny Antommarrina, Derek Williams. *Workshop Presenter*, Pediatric Hospital Medicine Annual Meeting, “IRB Approved! Tips and Tricks to Smooth Sailing through the Institutional Review Board (IRB).” Atlanta, Georgia, July 20.
10. 2018, Alan Schroeder, Armand H. Matheny Antommarrina, Hannah Bassett, Kevin Chi, Shawn Ralston, Rebecca Blankenburg. *Workshop Speaker*, Pediatric Hospital Medicine Annual Meeting, “When You Don’t Agree with the Plan: Balancing Diplomacy, Value, and Moral Distress,” Atlanta, Georgia, July 20.
11. 2018, Alan Schroeder, Hannah Bassett, Rebecca Blankenburg, Kevin Chi, Shawn Ralston, Armand H. Matheny Antommarrina. *Workshop Speaker*, Pediatric Academic Societies Annual Meeting, “When You Don’t Agree with the Plan: Balancing Diplomacy, Value, and Moral Distress,” Toronto, Ontario, Canada, May 7.
12. 2017, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Tensions in Informed Consent for Gender Affirming Hormone Therapy and Fertility Preservation in Transgender Adolescents,” Kansas City, Missouri, October 19.
13. Lindsey Douglas, Armand H. Matheny Antommarrina, and Derek Williams. 2017, *Workshop Leader*, PHM[Pediatric Hospital Medicine]2017, “IRB Approved! Tips and Tricks to Smooth Sailing through the Institutional Review Board (IRB) Process,” Nashville, Tennessee, July 21.
14. 2016, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Ethical Challenges in the Care of International Patients: Organization, Justice, and Cultural Considerations,” Washington, DC, October 9.
15. 2015, *Coauthor*, The American Society of Human Genetics Annual Meeting, “Adolescents’ Opinions on Disclosure of Non-Actionable Secondary Findings in Whole Exome Sequencing,” Baltimore, Maryland, October 9.
16. 2012, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “A Public Health Ethics Analysis of the Mandatory Immunization of Healthcare Personnel: Minimizing Burdens and Increasing Fairness,” Washington, DC, October 21.
17. Armand H. Matheny Antommarrina, Valerie Gutmann Koch, Susie A. Han, Carrie S. Zoubul. 2012, *Moderator*, American Society for Bioethics and Humanities Annual Meeting, “Representing the

Underrepresented in Allocating Scarce Resources in a Public Health Emergency: Ethical and Legal Considerations,” Washington, DC, October 21.

18. 2012, *Platform Presentation*, Pediatric Academic Societies Annual Meeting, “Qualitative Analysis of International Variation in Donation after Circulatory Death Policies and Rates,” Boston, Massachusetts, April 30. Publication 3150.4.
19. 2011, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “The Intersection of Policy, Medicine, and Ethics during a Public Health Disaster: Special Considerations for Children and Families,” Minneapolis, Minnesota, October 13.
20. Armand H. Matheny Antommara and Joel Frader. 2010, *Workshop Leader*, Pediatric Academic Societies Annual Meeting, “Conscientious Objection in Health Care: Respecting Conscience and Providing Access,” Vancouver, British Columbia, Canada. May 1. Session 1710.
21. 2009, *Workshop Leader*, American Society for Bioethics and Humanities Annual Meeting, “Advanced Clinical Ethics Consultation Skills Workshop: Process and Interpersonal Skills,” Washington, DC, October 15.
22. 2009, *Platform Presentation*, Pediatric Academic Societies Annual Meeting, “Qualitative Analysis of Donation after Cardiac Death Policies at Children’s Hospitals,” Baltimore, Maryland, May 2. Publication 2120.6.
23. 2008, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Qualitative Analysis of Donation After Cardiac Death (DCD) Policies at Children’s Hospitals,” Cleveland, Ohio, October 26.
24. 2007, *Participant*, Hamline University School of Law Biennial Symposium on Advanced Issues in Dispute Resolution, “An Intentional Conversation About Conflict Resolution in Health Care,” Saint Paul, Minnesota, November 8-10.
25. 2007, *Speaker*, American Society of Bioethics and Humanities Annual Meeting, “Bioethics Consultation and Alternative Dispute Resolution: Opportunities for Collaboration,” Washington, DC, October 21.
26. 2007, *Speaker*, American Society of Bioethics and Humanities Annual Meeting, “DNAR Orders in Schools: Collaborations Beyond the Hospital,” Washington, DC, October 18.
27. Armand H. Matheny Antommara and Jeannie DePaulis. 2007, *Speaker*, National Association of Children’s Hospitals and Related Institutions Annual Meeting, “Using Mediation to Address Conflict and Form Stronger Therapeutic Alliances,” San Antonio, Texas, October 9.
28. 2006, *Speaker*, American Society of Bioethics and Humanities Annual Meeting, “Bioethics Mediation: A Critique,” Denver, Colorado, October 28.
29. 2005, *Panelist*, American Society of Bioethics and Humanities Annual Meeting, “How I See This Case: ‘He Is Not His Brain,’” Washington, DC, October 20.
30. 2005, *Paper Presentation*, Pediatric Ethics: Setting an Agenda for the Future, The Cleveland Clinic, “‘He Is Not His Brain:’ Accommodating Objections to ‘Brain Death,’” Cleveland, Ohio, September 9.
31. 2004, *Speaker*, American Society for Bioethics and Humanities Spring Meeting, “Verification and Balance: Reporting Within the Constraints of Patient Confidentiality,” San Antonio, Texas, March 13.
32. 2002, *Panelist*, American Society for Bioethics and Humanities Annual Meeting, “‘Who Should Survive?:’ Mental Retardation and the History of Bioethics,” Baltimore, Maryland, October 24.

Invited/Visiting Professor Presentations

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

Grand Round Presentations

1. 2019, David Green Lectureship, “Establishing Goals of Care and Ethically Limiting Treatment,” Primary Children’s Hospital, Salt Lake City, Utah, December 5.
2. 2018, “The Ethics of Medical Intervention for Transgender Youth,” El Rio Health, Tucson, Arizona, September 29.
3. 2018, Pediatrics, “Patient Selection, Justice, and Cultural Difference: Ethical Issues in the Care of International Patients,” Cleveland Clinic, Cleveland, Ohio, April 10.
4. 2018, Bioethics, “Reversibility, Fertility, and Conflict: Ethical Issues in the Care of Transgender and Gender Nonconforming Children and Adolescents,” Cleveland Clinic, Cleveland, Ohio, April 9.
5. 2017, Heart Institute, “‘Have you ever thought about what you would want—if god forbid—you became sicker?’: Talking with adult patients about advance directives,” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, October 16.
6. 2017, Pediatrics, “Respectful, Effective Treatment of Jehovah’s Witnesses,” with Judith R. Ragsdale, PhD, MDiv and David Morales, MD, Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, March 14.
7. 2017, Pediatrics, “Ethical Dilemmas about Discharging Patients When There Are Disagreements Concerning Safety,” Seattle Children’s Hospital, Seattle, Washington, January 19.
8. 2015, Pediatrics, “‘Nonbeneficial’ Treatment: What must providers offer and what can they withhold?,” Greenville Health System, Greenville, South Carolina, May 10.
9. 2014, Advance Practice Providers, “Common Ethical Issues,” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, August 13.
10. 2014, Respiratory Therapy, “Do-Not-Resuscitate (DNR) Orders,” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, July 15.
11. 2013, Heart Institute, “No Not Months. Twenty-Two *Years*-Old: Transiting Patients to an Adult Model of Care,” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, October 21.
12. 2013, Division of Neonatology, “This Premature Infant Has a *BRCA1* Mutation!?: Ethical Issues in Clinical Whole Exome Sequencing for Neonatologists,” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, October 11.
13. 2013, Department of Pediatrics, “Adults are Not Large Children: Ethical Issues in Caring for Adults in Children’s Hospitals,” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, February 26.
14. 2012, “Mandate or Moratorium?: Persisting Ethical Controversies in Donation after Circulatory Death,” Cedars-Sinai Medical Center, Los Angeles, California, May 16.
15. 2011, Division of Pediatric Neurology Friday Lecture Series, “Inducing or Treating ‘Seizures’ with Placebos: Is It Ever Ethical?,” University of Utah, Salt Lake City, Utah, October 7.
16. 2011, Department of Surgery, “DNR Orders in the OR and other Ethical Issues in Pediatric Surgery: Case Discussions,” Primary Children’s Medical Center, Salt Lake City, Utah, October 3.
17. 2009, Department of Pediatrics, “What to Do When Parents Want Everything Done: ‘Futility’ and Bioethical Mediation,” Primary Children’s Medical Center, Salt Lake City, Utah, September 17.
18. 2008, Division of Pulmonology and Critical Care, “Futility: May Clinicians Ever Unilaterally Withhold or Withdraw Medical Treatment?” Utah Valley Regional Medical Center, Provo, Utah, April 17.
19. 2007, Division of Otolaryngology-Head and Neck Surgery, “Advance Directives, Durable Powers of Attorney for Healthcare, and Do Not Attempt Resuscitation Orders: Oh My!,” University of Utah School of Medicine, Salt Lake City, Utah, June 20.

Outreach Presentations

1. 2019, *Panelist*, Cincinnati Edition, WVXU, “The Ethics of Human Gene Editing,” Cincinnati, Ohio, June 13.
2. 2019, *Speaker*, Adult Forum, Indian Hill Church, “Medical Ethics,” Indian Hill, Ohio, March 24.

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

Podcasts

1. 2021, “Ethics of COVID Vaccines in Kids,” PHM from Pittsburgh, August 12.
2. 2020, COVID Quandaries: Episode 1, “Is Getting Sick Just Part of the Job?” Hard Call, October 6.

EXHIBIT C

EXHIBIT C

TABLE 1: Strength of Recommendation and Quality of Evidence in Recommendations Made by the Endocrine Society

Strength of the Recommendation/ Quality of the Evidence ¹	Endocrine Treatment of Gender-Dysphoric/Gender- Incongruent Persons	Pediatric Obesity- Assessment, Treatment, and Prevention	Congenital Adrenal Hyperplasia Due to Steroid 21-Hydroxylase Deficiency
Strong High	0 (0) ²	0 (0)	0 (0)
Strong Moderate	3 (11)	4 (13)	18 (33)
Strong Low	5 (18)	6 (20)	13 (25)
Strong Very Low	2 (7)	1 (3)	1 (2)
Weak High	0 (0)	0 (0)	0 (0)
Weak Moderate	0 (0)	0 (0)	2 (4)
Weak Low	9 (32)	5 (17)	4 (7)
Weak Very Low	3 (11)	12 (40)	7 (13)
Ungraded Good Practice Statement ³	6 (21)	2 (7)	9 (17)
Either Low or Very Low	19 (68)	24 (80)	25 (46)
Total	28	30	54

¹ Quality of the Evidence

High: “Consistent evidence from well-performed RCTs [Randomized Controlled Trials] or exceptionally strong evidence from unbiased observational studies”

Moderate: “Evidence from RCTs with important limitations (inconsistent results, methodological flaws, indirect or imprecise evidence), or unusually strong evidence from unbiased observational studies”

Low: “Evidence for at least one critical outcomes from observational studies, from RCTs with serious flaws, or indirect evidence”

Very Low: “Evidence for at least one of the critical outcomes from unsystematic clinical observations or very indirect evidence”

See Swiglo BA, Murad MH, Schunemann HJ, et al. A case for clarity, consistency, and helpfulness: State-of-the-art clinical practice guidelines in endocrinology using the grading of recommendations, assessment, development, and evaluation system. *J Clin Endocrinol Metab.* 2008;93(3):666-73.

² n (%)

³Ungraded Good Practice Statement: “Direct evidence for these statements was either unavailable or not systematically appraised and considered out of the scope of this guideline. The intention of these statements is to draw attention to these principles.” See Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2017;102(11):3869-3903.

Guidelines:

Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2017;102(11):3869-3903.

Styne DM, Arslanian SA, Connor EL, et al. Pediatric obesity-assessment, treatment, and prevention: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2017;102(3):709-757.

Speiser PW, Arlt W, Auchus RJ, et al. Congenital adrenal hyperplasia due to steroid 21-hydroxylase deficiency: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2018;103(11):4043-4088.

DOC. 69

**UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION**

REV. PAUL A. EKNES-TUCKER,	)	
<i>et al.</i> ,	)	
	)	
<i>Plaintiffs</i> ,	)	
	)	
v.	)	No. 2:22-cv-00184-LCB-SRW
	)	
KAY IVEY, in her official capacity	)	
as Governor of the State of Alabama,	)	
<i>et al.</i> ,	)	
	)	
<i>Defendants.</i>	)	

**DEFENDANTS' EXHIBIT LIST AND NOTICE OF FILING
OF EVIDENCE IN OPPOSITION TO PLAINTIFFS' MOTION
FOR PRELIMINARY INJUNCTION**

Defendants 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 Blaylock, 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, submit the following exhibit list for the preliminary injunction hearing scheduled for May 5 and 6, 2022. Defendants also give notice of the filing of the exhibits listed below. These same exhibits will be cited in

Defendants' brief in opposition to the Plaintiffs' motion, which will be filed separately.

Exhibit List

- D1 Alabama Vulnerable Child Compassion and Protection Act, Act 2022-289 (SB184)
- D2 Declaration of Dr. James Cantor, Ph.D.
- D3 Declaration of Dr. Michael K. Laidlaw, M.D.
- D4 Declaration of Dr. Quentin L. Van Meter, M.D.
- D5 Declaration of Dr. Paul W. Hruz, M.D., Ph.D.
- D6 Declaration of Dr. Patrick Hunter, M.D.
- D7 Declaration of Dr. Dianna Kenny, Ph.D.
- D8 Stephen B. Levine, E. Abbruzzese & Julia M. Mason, *Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults*, J. OF SEX & MARITAL THERAPY (Mar. 17, 2022)
- D9 *Evidence Review: Gonadotropin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria*, Nat'l Inst. for Health & Care Excellence (NICE) (released Mar. 11, 2021), *available at* <https://arms.nice.org.uk/resources/hub/1070905/attachment>
- D10 *Evidence Review: Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria*, Nat'l Inst. for Health & Care Excellence (NICE) (released Mar. 11, 2021), *available at* <https://arms.nice.org.uk/resources/hub/1070871/attachment>
- D11 Sweden National Board of Health and Welfare Policy Statement, Socialstyrelsen, *Care of Children and Adolescents with Gender Dysphoria: Summary* (2022) *available at* <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf>

- D12 Finland's Council for Choices in Healthcare Policy Statement, Palveluvalikoima, *Recommendation of the Council for Choices in Health Care in Finland (PALKO / COHERE Finland)* unofficial translation by Society for Evidence Based Medicine available in English at https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf
- D13 Académie Nationale de Médecine, *Medicine and Gender Transidentity in Children and Adolescents* (Feb. 25, 2022), available at <https://www.academie-medecine.fr/wp-content/uploads/2022/03/22.2.25-Communiqu-PCRA-19-Gender-identity-ENG.pdf>
- D14 The Royal Australian & New Zealand College of Psychiatrists, *Recognising and Address the Mental Health Needs of People Experiencing Gender Dysphoria / Gender Incongruence*, Position Statement 103 (Aug. 2021), available at <https://perma.cc/LR94-73ZU>
- D15 *Bell v. Tavistock & Portman Nat'l Health Serv. Found. Tr.* [2020] EWHC (Admin) 3274
- D16 Centers for Medicare & Medicaid Services, Tamara Syrek Jensen, et al., *Decision Memo for Gender Dysphoria and Gender Reassignment Surgery* (CAG-00446N) (Aug. 30, 2016), available at <https://perma.cc/9CQN-938N>
- D17 Am. Psychiatric Ass'n, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) (excerpts)
- D18 World Professional Ass'n for Transgender Health (WPATH), *Standards of Care for the Health of Transsexual, Transgender, and Gender-Conforming People* (7th Version) (2012)
- D19 Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guidelines*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869 (Nov. 2017)
- D20 Lisa Littman, *Parent Reports of Adolescents & Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*, PLOS ONE 13(8):e0202330

- D21 Lisa Littman, *Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition who Subsequently Detransitioned: A Survey of 100 Detransitioners*, 50 ARCHIVES OF SEXUAL BEHAVIOR No. 50, 3353-54 (Oct. 2021)
- D22 Elie Vandebussche, *Detransition-Related Needs and Support: A Cross-Sectional Online Survey*, JOURNAL OF HOMOSEXUALITY (Apr. 30, 2021), available at <https://doi.org/10.1080/00918369.2021.1919479>
- D23 Annelou de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 130 PEDIATRICS, No. 4, 696-704 (Oct. 2014)
- D24 Jason Rafferty, *Policy Statement, Am. Academy of Pediatrics, Ensuring Comprehensive Care & Support for Transgender & Gender-Diverse Children & Adolescents*, 142 Pediatrics no. 4, at 3 (Oct. 2018), available at <https://perma.cc/EE6U-PN66>
- D25 Am. Psych. Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 Am. Psychologist 832, 836 (Dec. 2015), available at <https://www.apa.org/practice/guidelines/transgender.pdf>
- D26 Declaration of Corinna Cohn
- D27 Declaration of Sydney Wright
- D28 Declaration of Carol Frietas
- D29 Declaration of Barbara F.*
- D30 Declaration of John Doe*
- D31 Declaration of John Roe*
- D32 Declaration of Kristine W.*
- D33 Declaration of Yaacov Sheinfeld

* Proceeding using a pseudonym to protect the privacy of minor children suffering from gender dysphoria.

D34 Declaration of Martha S.*

D35 Declaration of KathyGrace Duncan

D36 Declaration of Jeanne Crowley*

D37 Declaration of Ted H. Halley

D38 Declaration of Kellie C.*

D39 Declaration of Gary Warner

D40 April 15, 2022 emails regarding *Ladinsky v. Ivy* litigation

Defendants reserve the right to proffer rebuttal exhibits, impeachment exhibits, and any exhibit listed by another party to this action. Pursuant to this Court's order (doc. 34), Defendants file a copy of each exhibit.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that I electronically filed this document using the Court's CM/ECF system on May 2, 2022, which will serve all counsel of record.

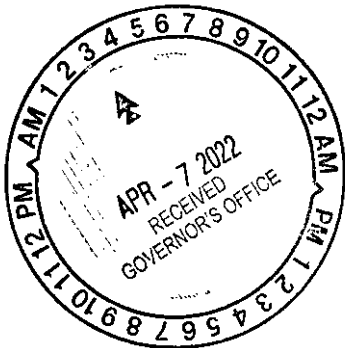
s/ James W. Davis
Counsel for Defendants

DOC. 69-1

ACT #2022 - 289



1 SB184
2 216600-4
3 By Senators Shelnutt and Allen
4 RFD: Healthcare
5 First Read: 03-FEB-22



SB184

1 SB184

2
3
4 ENROLLED, An Act,

5 Relating to public health; to prohibit the
6 performance of a medical procedure or the prescription of
7 medication, upon or to a minor child, that is intended to
8 alter the minor child's gender or delay puberty; to provide
9 for exceptions; to provide for disclosure of certain
10 information concerning students to parents by schools; and to
11 establish criminal penalties for violations; and in connection
12 therewith would have as its purpose or effect the requirement
13 of a new or increased expenditure of local funds within the
14 meaning of Amendment 621 of the Constitution of Alabama of
15 1901, as amended by Amendment 890, now appearing as Section
16 111.05 of the Official ReCompilation of the Constitution of
17 Alabama of 1901, as amended.

18 BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

19 Section 1. This act shall be known and may be cited
20 as the Alabama Vulnerable Child Compassion and Protection Act
21 (V-CAP).

22 Section 2. The Legislature finds and declares the
23 following:

24 (1) The sex of a person is the biological state of
25 being female or male, based on sex organs, chromosomes, and

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1 endogenous hormone profiles, and is genetically encoded into a
2 person at the moment of conception, and it cannot be changed.

3 (2) Some individuals, including minors, may
4 experience discordance between their sex and their internal
5 sense of identity, and individuals who experience severe
6 psychological distress as a result of this discordance may be
7 diagnosed with gender dysphoria.

8 (3) The cause of the individual's impression of
9 discordance between sex and identity is unknown, and the
10 diagnosis is based exclusively on the individual's self-report
11 of feelings and beliefs.

12 (4) This internal sense of discordance is not
13 permanent or fixed, but to the contrary, numerous studies have
14 shown that a substantial majority of children who experience
15 discordance between their sex and identity will outgrow the
16 discordance once they go through puberty and will eventually
17 have an identity that aligns with their sex.

18 (5) As a result, taking a wait-and-see approach to
19 children who reveal signs of gender nonconformity results in a
20 large majority of those children resolving to an identity
21 congruent with their sex by late adolescence.

22 (6) Some in the medical community are aggressively
23 pushing for interventions on minors that medically alter the
24 child's hormonal balance and remove healthy external and

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1 internal sex organs when the child expresses a desire to
2 appear as a sex different from his or her own.

3 (7) This course of treatment for minors commonly
4 begins with encouraging and assisting the child to socially
5 transition to dressing and presenting as the opposite sex. In
6 the case of prepubertal children, as puberty begins, doctors
7 then administer long-acting GnRH agonist (puberty blockers)
8 that suppress the pubertal development of the child. This use
9 of puberty blockers for gender nonconforming children is
10 experimental and not FDA-approved.

11 (8) After puberty blockade, the child is later
12 administered "cross-sex" hormonal treatments that induce the
13 development of secondary sex characteristics of the other sex,
14 such as causing the development of breasts and wider hips in
15 male children taking estrogen and greater muscle mass, bone
16 density, body hair, and a deeper voice in female children
17 taking testosterone. Some children are administered these
18 hormones independent of any prior pubertal blockade.

19 (9) The final phase of treatment is for the
20 individual to undergo cosmetic and other surgical procedures,
21 often to create an appearance similar to that of the opposite
22 sex. These surgical procedures may include a mastectomy to
23 remove a female adolescent's breasts and "bottom surgery" that
24 removes a minor's health reproductive organs and creates an

SB184

1 artificial form aiming to approximate the appearance of the
2 genitals of the opposite sex.

3 (10) For minors who are placed on puberty blockers
4 that inhibit their bodies from experiencing the natural
5 process of sexual development, the overwhelming majority will
6 continue down a path toward cross-sex hormones and cosmetic
7 surgery.

8 (11) This unproven, poorly studied series of
9 interventions results in numerous harmful effects for minors,
10 as well as risks of effects simply unknown due to the new and
11 experimental nature of these interventions.

12 (12) Among the known harms from puberty blockers is
13 diminished bone density; the full effect of puberty blockers
14 on brain development and cognition are yet unknown, though
15 reason for concern is now present. There is no research on the
16 long-term risks to minors of persistent exposure to puberty
17 blockers. With the administration of cross-sex hormones comes
18 increased risks of cardiovascular disease, thromboembolic
19 stroke, asthma, COPD, and cancer.

20 (13) Puberty blockers prevent gonadal maturation and
21 thus render patients taking these drugs infertile. Introducing
22 cross-sex hormones to children with immature gonads as a
23 direct result of pubertal blockade is expected to cause
24 irreversible sterility. Sterilization is also permanent for
25 those who undergo surgery to remove reproductive organs, and

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1 such persons are likely to suffer through a lifetime of
2 complications from the surgery, infections, and other
3 difficulties requiring yet more medical intervention.

4 (14) Several studies demonstrate that hormonal and
5 surgical interventions often do not resolve the underlying
6 psychological issues affecting the individual. For example,
7 individuals who undergo cross-sex cosmetic surgical procedures
8 have been found to suffer from elevated mortality rates higher
9 than the general population. They experience significantly
10 higher rates of substance abuse, depression, and psychiatric
11 hospitalizations.

12 (15) Minors, and often their parents, are unable to
13 comprehend and fully appreciate the risk and life
14 implications, including permanent sterility, that result from
15 the use of puberty blockers, cross-sex hormones, and surgical
16 procedures.

17 (16) For these reasons, the decision to pursue a
18 course of hormonal and surgical interventions to address a
19 discordance between the individual's sex and sense of identity
20 should not be presented to or determined for minors who are
21 incapable of comprehending the negative implications and
22 life-course difficulties attending to these interventions.

23 Section 3. For the purposes of this act, the
24 following terms shall have the following meanings:

SB184

1 (1) MINOR. The same meaning as in Section 43-8-1,
2 Code of Alabama 1975.

3 (2) PERSON. Includes any of the following:

4 a. Any individual.

5 b. Any agent, employee, official, or contractor of
6 any legal entity.

7 c. Any agent, employee, official, or contractor of a
8 school district or the state or any of its political
9 subdivisions or agencies.

10 (3) SEX. The biological state of being male or
11 female, based on the individual's sex organs, chromosomes, and
12 endogenous hormone profiles.

13 Section 4. (a) Except as provided in subsection (b),
14 no person shall engage in or cause any of the following
15 practices to be performed upon a minor if the practice is
16 performed for the purpose of attempting to alter the
17 appearance of or affirm the minor's perception of his or her
18 gender or sex, if that appearance or perception is
19 inconsistent with the minor's sex as defined in this act:

20 (1) Prescribing or administering puberty blocking
21 medication to stop or delay normal puberty.

22 (2) Prescribing or administering supraphysiologic
23 doses of testosterone or other androgens to females.

24 (3) Prescribing or administering supraphysiologic
25 doses of estrogen to males.

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1 (4) Performing surgeries that sterilize, including
2 castration, vasectomy, hysterectomy, oophorectomy,
3 orchiectomy, and penectomy.

4 (5) Performing surgeries that artificially construct
5 tissue with the appearance of genitalia that differs from the
6 individual's sex, including metoidioplasty, phalloplasty, and
7 vaginoplasty.

8 (6) Removing any healthy or non-diseased body part
9 or tissue, except for a male circumcision.

10 (b) Subsection (a) does not apply to a procedure
11 undertaken to treat a minor born with a medically verifiable
12 disorder of sex development, including either of the
13 following:

14 (1) An individual born with external biological sex
15 characteristics that are irresolvably ambiguous, including an
16 individual born with 46 XX chromosomes with virilization, 46
17 XY chromosomes with under virilization, or having both ovarian
18 and testicular tissue.

19 (2) An individual whom a physician has otherwise
20 diagnosed with a disorder of sexual development, in which the
21 physician has determined through genetic or biochemical
22 testing that the person does not have normal sex chromosome
23 structure, sex steroid hormone production, or sex steroid
24 hormone action for a male or female.

25 (c) A violation of this section is a Class C felony.

SB184

1 Section 5. No nurse, counselor, teacher, principal,
2 or other administrative official at a public or private school
3 attended by a minor shall do either of the following:

4 (1) Encourage or coerce a minor to withhold from the
5 minor's parent or legal guardian the fact that the minor's
6 perception of his or her gender or sex is inconsistent with
7 the minor's sex.

8 (2) Withhold from a minor's parent or legal guardian
9 information related to a minor's perception that his or her
10 gender or sex is inconsistent with his or her sex.

11 Section 6. Except as provided for in Section 4,
12 nothing in this act shall be construed as limiting or
13 preventing psychologists, psychological technicians, and
14 master's level licensed mental health professionals from
15 rendering the services for which they are qualified by
16 training or experience involving the application of recognized
17 principles, methods, and procedures of the science and
18 profession of psychology and counseling.

19 Section 7. Nothing in this section shall be
20 construed to establish a new or separate standard of care for
21 hospitals or physicians and their patients or otherwise
22 modify, amend, or supersede any provision of the Alabama
23 Medical Liability Act of 1987 or the Alabama Medical Liability
24 Act of 1996, or any amendment or judicial interpretation of
25 either act.

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1 Section 8. If any part, section, or subsection of
2 this act or the application thereof to any person or
3 circumstances is held invalid, the invalidity shall not affect
4 parts, sections, subsections, or applications of this act that
5 can be given effect without the invalid part, section,
6 subsection, or application.

7 Section 9. This act does not affect a right or duty
8 afforded to a licensed pharmacist by state law.

9 Section 10. Although this bill would have as its
10 purpose or effect the requirement of a new or increased
11 expenditure of local funds, the bill is excluded from further
12 requirements and application under Amendment 621, as amended
13 by Amendment 890, now appearing as Section 111.05 of the
14 Official Recompilation of the Constitution of Alabama of 1901,
15 as amended, because the bill defines a new crime or amends the
16 definition of an existing crime.

17 Section 11. This act shall become effective 30 days
18 following its passage and approval by the Governor, or its
19 otherwise becoming law.

SB184



President and Presiding Officer of the Senate



Speaker of the House of Representatives

SB184

Senate 23-FEB-22

I hereby certify that the within Act originated in and passed
the Senate, as amended.

Patrick Harris,
Secretary.

House of Representatives
Passed: 07-APR-22

By: Senator Shelnutt

APPROVED

4-8-2022

TIME

2:10 pm


GOVERNOR

Alabama Secretary Of State

Act Num.....: 2022-289
Bill Num....: S-184

Recv'd 04/08/22 02:23pmSLF

SPONSOR

1 Shelduck
CO-SPONSORS

2 Allen 19
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I hereby certify that the Resolution as required in Section C of Act No. 81-889 was adopted and is attached to the Bill, SB 184.

yeas 24 nays 4 abstain 0

PATRICK HARRIS,
Secretary

I hereby certify that the notice & proof is attached to the Bill, SB _____ as required in the General Acts of Alabama, 1975 Act No. 919.

PATRICK HARRIS,
Secretary

CONFERENCE COMMITTEE

Senate Conferees _____

DATE:

2-24

RD 1 RFD

Yody

REPORT OF STANDING COMMITTEE

This bill having been referred by the House to its/standing committee on _____ was acted upon by such committee in session, and returned therefrom to the House with the recommendation that it be Passed w/amend(s) w/sub _____ This 2 day of March, 2022.

Chairperson

DATE:

3-2

RF

RD 2

DATE:

RE-REFERRED ☐

RE-COMMITTED ☐

Committee _____

I hereby certify that the Resolution as required in Section C of Act No. 81-889 was adopted and is attached to the Bill, SB _____

YEAS _____ NAYS _____

JEFF WOODARD,
Clerk

FURTHER HOUSE ACTION (OVER)

DOC. 69-2

**UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION**

REV. PAUL A. EKNES-TUCKER,	)	
<i>et al.</i> ,	)	
	)	
<i>Plaintiffs</i> ,	)	
	)	
v.	)	No. 2:22-cv-00184-LCB-SRW
	)	
KAY IVEY, in her official capacity	)	
as Governor of the State of Alabama,	)	
<i>et al.</i> ,	)	
	)	
<i>Defendants.</i>	)	

DECLARATION OF DR. JAMES CANTOR

My name is James Michael Cantor. I am over the age of 19, I am qualified to give this declaration, and, I have personal knowledge of the matters set forth herein.

My CV is attached to this declaration. Recent publications are listed on my CV.

In the past four years, I have provided expert testimony in the following cases:

2022	Hersom & Doe v WVa Health & Human Services	Southern Dist, West Virginia
2022	BPJ v WVa Board of Education	Southern Dist, West Virginia
2021	Cross et al. v Loudoun School Board	Loudoun, Virginia
2021	Allan M. Josephson v Neeli Bendapudi	Western District of Kentucky
2021	Re Commitment of Michael Hughes (Frye Hearing)	Cook County, Illinois
2019	US vs Peter Bright	Southern Dist, NY, NY
2019	Probate and Family Court (Custody Hearing)	Boston, Massachusetts
2019	Re Commitment of Steven Casper (Frye Hearing)	Kendall County, Illinois
2019	Re Commitment of Inger (Frye Hearing)	Poughkeepsie, New York
2018	Re Commitment of Fernando Little (Frye Hearing)	Utica, New York
2018	Canada vs John Fitzpatrick (Sentencing Hearing)	Toronto, Ontario, Canada

I am compensated a the rate of \$400 per hour for my work on this matter. My compensation is not dependent upon the substance of my opinions or the outcome of the case.

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I. Introduction

A. Background & Credentials

1. I am a clinical psychologist and Director of the Toronto Sexuality Centre in Canada. For my education and training, I received my Bachelor of Science degree from Rensselaer Polytechnic Institute, where I studied mathematics, physics, and computer science. I received my Master of Arts degree in psychology from Boston University, where I studied neuropsychology. I earned my Doctoral degree in psychology from McGill University, which included successfully defending my doctoral dissertation studying the effects of psychiatric medication and neurochemical changes on sexual behavior, and included a clinical internship assessing and treating people with a wide range of sexual and gender identity issues.

2. Over my academic career, my posts have included Psychologist and Senior Scientist at the Centre for Addiction and Mental Health (CAMH) and Head of Research for CAMH's Sexual Behaviour Clinic, Associate Professor of Psychiatry on the University of Toronto Faculty of Medicine, and Editor-in-Chief of the peer reviewed journal, *Sexual Abuse*. That journal is one of the top-impact, peer-reviewed journals in sexual behavior science and is the official journal of the Association for the Treatment of Sexual Abusers. In that appointment, I was charged to be the final arbiter for impartially deciding which contributions from other scientists in my field merited publication. I believe that appointment indicates not only my extensive experience evaluating scientific claims and methods, but also the faith put in me by the other scientists in my field. I have also served on the Editorial Boards of the *Journal of Sex Research*, the *Archives of Sexual Behavior*, and *Journal of Sexual Aggression*. Thus, although I cannot speak for other scientists, I regularly interact with and am routinely exposed to the views and opinions of most of the scientists active in our field today, within the United States and throughout the world.

3. My scientific expertise spans the biological and non-biological development

of human sexuality, the classification of sexual interest patterns, the assessment and treatment of atypical sexualities, and the application of statistics and research methodology in sex research. I am the author of over 50 peer-reviewed articles in my field, spanning the development of sexual orientation, gender identity, hypersexuality, and atypical sexualities collectively referred to as *paraphilias*. I am the author of the past three editions of the gender identity and atypical sexualities chapter of the *Oxford Textbook of Psychopathology*. These works are now routinely cited in the field and are included in numerous other textbooks of sex research.

4. I began providing clinical services to people with gender dysphoria in 1998. I trained under Dr. Ray Blanchard of CAMH and have participated in the assessment of treatment of over one hundred individuals at various stages of considering and enacting both transition and detransition, including its legal, social, and medical (both cross-hormonal and surgical) aspects. My clinical experience includes the assessment and treatment of several thousand individuals experiencing other atypical sexuality issues. I am regularly called upon to provide objective assessment of the science of human sexuality by the courts (prosecution and defense), professional media, and mental health care providers.

5. I have served as an expert witness in 11 cases in the past five years. These are listed on my *curriculum vitae*, attached here as Appendix 1.

6. A substantial proportion of the existing research on gender dysphoria comes from two clinics, one in Canada and one in the Netherlands. The CAMH gender clinic (previously, Clarke Institute of Psychiatry) was in operation for several decades, and its research was directed by Dr. Kenneth Zucker. I was employed by CAMH between 1998 and 2018. I was a member of the hospital's adult forensic program. However, I was in regular contact with members of the CAMH child psychiatry program (of which Dr. Zucker was a member), and we collaborated on multiple projects.

7. For my work in this case, I am being compensated at the hourly rate of \$400

per hour. My compensation does not change based on the conclusions and opinions that I provide here or later in this case or on the outcome of this lawsuit.

B. Overview

8. The principal opinions that I offer and explain in detail in this report include that:

- a. A ban on medical transition services for youth under age 18 is consistent with international standards;
- b. The large majority of gender dysphoric, pre-pubescent youth cease to feel gender dysphoric by puberty;
- c. Among youth under age 18, follow-up studies show positive results in association with psychotherapy, not medically aided transition; and
- d. Follow-up studies of medical transition have shown positive results only in samples of adults ages 18 and older.

9. To prepare the present report, I reviewed the following resources related to this litigation:

- a. Text of Alabama Bill SB-184;
- b. Memorandum in support of plaintiffs' motion for temporary restraining order & preliminary injunction;
- c. Declaration of Linda A. Hawkins, Ph.D., LPC in support of plaintiffs' motion for temporary restraining order & preliminary injunction;
- d. Declaration of Morissa J. Ladinsky, MD, FAAP, in support of plaintiffs' motion for temporary restraining order & preliminary injunction;
- e. Declaration of Stephen Rosenthal, MD, in support of plaintiffs' motion for temporary restraining order & preliminary injunction.

II. Fact-Check of Assertions of Plaintiffs' Experts' Reports

10. I have reviewed the memorandum supporting the plaintiffs' motion, including its declarations by Drs. Hawkins, Ladinsky, and Rosenthal, and compared

its claims with the published, peer-reviewed scientific literature of gender dysphoria, its treatment and outcomes. The motion and all three experts asserted very many very bold claims, but vanishingly little citation of any objective science at all. Of the many hundred relevant, peer-reviewed research articles on this topic, Dr. Hawkins cited three, Dr. Ladinsky cited none at all, and Dr. Rosenthal cited eight, four of which were from the same research team, also cited by Dr. Hawkins. As demonstrated in the following, that small set of articles represents a highly cherry-picked misrepresentation of the relevant body of science, failing to reflect the consensus of the research literature. Their declarations not only fail to reflect the consensus of the science, but also repeatedly assert claims in direct opposition to that science. A comprehensive summary of the research literature on gender dysphoria is provided herein.

A. Professional and International Standards of Care

11. The claims expressed in the plaintiffs' documents largely rely on their claims of professional standards, citing the American Association of Pediatrics (AAP), the World Professional Association for Transgender Health (WPATH), and the Endocrine Society. In so doing, the plaintiffs provided only misleading half-truths, yielding only an incomplete and inaccurate portrayal of the field. Missing from the plaintiffs documentation were that these standards have repeatedly been found to be wanting, that their application has failed to produce improvement among patients, and that it is these U.S.-based associations that are out of line with the international consensus of health care experts.

12. First, the plaintiffs' documentation misrepresents the contents of the associations' policies themselves. With the broad exception of the AAP, their statements repeatedly noted instead that:

- Desistance of gender dysphoria occurs in the majority of prepubescent children.

- Mental health issues need to be assessed as potentially contributing factors and need to be addressed before transition.
- Puberty-blocking medication is an experimental, not a routine, treatment.
- Social transition is not generally recommended until after puberty.

Although some other associations have published broad statements of moral support for sexual minorities and against discrimination, they did not include any specific standards or guidelines regarding medical- or transition-related care.

13. Second, the WPATH and the Endocrine Society guidelines have both been subjected to standardized evaluation, the Appraisal of Guidelines for Research and Evaluation (“AGREE II”) method, as part of an appraisal of all published CPGs regarding sex and gender minority healthcare.¹ Utilizing community stakeholders to set domain priorities for the evaluation, the assessment concluded that the guidelines regarding HIV and its prevention were of high quality, but that “[t]ransition-related CPGs tended to lack methodological rigour and rely on patchier, lower-quality primary research.”² Neither the Endocrine Society’s or WPATH’s guidelines were recommended for use. Indeed, the WPATH guidelines received unanimous ratings of “Do not recommend.”³ Thus, despite the exuberant adjectives offered in the plaintiffs’ experts’ reports, objective analysis yields the opposite conclusion.

14. The AAP differed from the other (U.S.-based) associations in outlining far less conservative clinical decision-making, but only in contradiction with the published research. Immediately following the publication of the AAP policy, I conducted a point-by-point fact-check of the claims it asserted and the references it cited in support. I submitted that to the *Journal of Sex & Marital Therapy*, a well-known research journal of my field, where it underwent blind peer review and was published. I append that article as part of this report. See Appendix 1. A great deal of published attention ensued; however, the AAP has yet to respond to the errors I

¹ Dahlen, *et al.*, 2021.

² Dahlen, *et al.*, 2021, at 6.

³ Dahlen, *et al.*, 2021, at 7.

demonstrated its policy contained. Writing for *The Economist* about the use of puberty blockers, Helen Joyce asked AAP directly, “Has the AAP responded to Dr Cantor? If not, have you any response now?” The AAP Media Relations Manager, Lisa Black, responded: “We do not have anyone available for comment.”

15. Finally, the opinions of these U.S.-based associations are in stark opposition to international standards: Public healthcare systems throughout the world have instead been withdrawing their earlier support for childhood transition, responding to the increasingly recognized risks associated with hormonal interventions and the now clear lack of evidence that medical transition was benefitting most children, as opposed to the mental health counseling accompanying transition. These have included the United Kingdom⁴, Finland,⁵ Sweden⁶, and France⁷.

B. Claims attributed to Olson and Durwood, *et al.*

16. The Hawkins and Rosenthal reports both cited Olson, *et al.* (2016), claiming it to demonstrate that transition reduce risk of mental illness. That claim entirely misrepresents, indeed reverses, the state of the scientific literature. Although Olson, *et al.* (2016) did indeed report that gender dysphoric children showed no mental health differences from the non-transgender control groups, that report turned out to be incorrect: Not pointed out by Drs Hawkins or Rosenthal is that the Olson data were subsequently subjected to a re-analysis and that, after correcting for statistical errors in the original analysis, the data instead showed that the gender dysphoric children under Olson’s care *did*, in fact, exhibit significantly lower mental health⁸.

17. I conducted an electronic search of the research literature to identify any

⁴ U.K. National Institute for Health and Care Excellence, 2020.

⁵ Council for Choices in Health Care in Finland, 2020.

⁶ Swedish National Board of Health and Welfare, 2022.

⁷ Académie Nationale de Médecine, 2022, Feb. 25.

⁸ Schumm & Crawford, 2020; Schumm, *et al.*, 2019.

responses from the Olson team regarding the Schumm and Crawford re-analysis of the Olson data and was not able to locate any. I contacted Professor Schumm by email on August 22, 2021 to verify that conclusion, to which he wrote there has been: “No response [from Olson]”⁹.

18. Rosenthal also cited a retrospective study from the Olson team, published as Durwood et al., 2017. That study surveyed children in the TransYouth Project—people who have socially transitioned, their families, and any contacts they had, by word of mouth. This method is referred to as “convenience sampling,” and differs from genuinely representative samples in applying to means of ensuring study participants accurately represent the population being studied. There were three groups of children for comparison: (i) children who had already socially transitioned, (ii) their siblings, and (iii) children in a university database of families interested in participating in child development research. As noted by the study authors, “For the first time, this article reports on socially transitioned gender children’s mental health as reported by the children.”¹⁰ Reports from parents were also recorded.¹¹ In contrast, no reports or ratings were provided by any mental health care professional or researcher at all. That is, although adding self-assessments to the professional assessments might indeed provide novel insights, this project did not add self-assessment to professional assessment. Rather, it replaced professional assessment with self-assessment. Moreover, as already noted, Olson’s data did not show what the Olson team claimed.¹² The dataset was subsequently re-analyzed, and “[T]o the contrary, the transgender children, even when supported by their parents, had significantly lower average scores on anxiety and self-worth.”¹³

19. It is well established in the field of psychology that participant self-

⁹ Schumm, email communication, Aug. 22, 2021 (on file with author).

¹⁰ Durwood, *et al.*, 2017, at 121 (italics added).

¹¹ See Olson, *et al.*, 2016.

¹² Schumm, *et al.*, 2019.

¹³ Schumm & Crawford, 2020, p. 9

assessment can be severely unreliable for multiple reasons. For example, one well-known phenomenon in psychological research is known as “socially desirable responding”—the tendency of subjects to give answers that they believe will make themselves look good, rather than accurate answers. Specifically, subjects’ reports that they are enjoying good mental health and functioning well could reflect the subjects’ desire to be *perceived* as healthy and as having made good choices, rather than reflecting their actual mental health.

20. In their analyses, the study reported finding no significant differences between the transgender children, their non-transgender siblings, or the community controls. As the authors noted, “[t]hese findings are in striking contrast to previous work with gender-nonconforming children who had not socially transitioned, which found very high rates of depression and anxiety.”¹⁴ The authors are correct to note that their result contrasts with the previous research, but they do not discuss that this could reflect a problem with the novel research design they used: The subjective self-reports of the children and their parents’ reports may not be reflecting reality objectively, as careful professional researchers would. Because the study did not employ any method to detect and control for participants indulging in “socially desirable responding” or acting under other biasing motivations, this possibility cannot be assessed or ruled out.

21. Because this was a single-time study relying on self-reporting, rather than a before-and-after transition study relying on professional evaluation, it is not possible to know if the children reported as well-functioning are in fact well-functioning, nor if so whether they are well-functioning because they were permitted to transition, or whether instead the fact is that they were already well-functioning and therefore permitted to transition. Finally, because the TransYouth project lacks a prospective design, it cannot be known how many cases attempted transition,

¹⁴ Durwood, *et al.*, 2017, at 116.

reacted poorly, and then detransitioned, thus never having entered into the study in the first place.

C. Claims attributed to de Vries, et al.

22. Drs. Hawkins and Rosenthal both cited de Vries, *et al.* (2014) to support their assertion that medical transition of minors improved their mental health. It is not possible for one to come to that conclusion from that study, however. The clinic treating these children (the originators of “The Dutch Protocol”¹⁵) provides psychotherapy together with medical services. In research science, this situation is called a “confound.” It is not possible to distinguish whether any changes were due to the medical services, the psychotherapy, or an interaction between them. Nonetheless, another study, left uncited by the plaintiff’s experts, demonstrated that improvements in mental health are associated with receiving psychotherapy rather than medical services. As detailed later in this report, Costa, *et al.*, (2015) conducted a follow-up study of youth in the U.K., one group receiving only psychotherapy, and one group first receiving only psychotherapy and then receiving both psychotherapy and medical services. Both groups improved, and the group receiving medical services failed to show significant differences from the group who received only psychotherapy throughout.

D. Claims attributed to Spack.

23. Dr. Rosenthal also misrepresented the views of Dr. Norman Spack. The article Rosenthal cited—Spack, 2012—repeatedly emphasized that children with gender dysphoria exhibit very many symptoms of mental illnesses. Spack asserted unambiguously that “Gender dysphoric children who do not receive *counseling* have a high risk of behavioural and emotional problems and psychiatric diagnoses”¹⁶. Dr. Rosenthal’s context misrepresents Spack so as to suggest Spack was advocating for

¹⁵ de Vries, *et al.*, 2011.

¹⁶ Spack, *et al.*, 2012, at 422, italics added.

medical transition to treat the gender dysphoria rather than counseling to treat suicidality and any other mental health issues. Moreover still, missing from the Rosenthal report was Spack's conclusion that "[m]ental health intervention should persist for the long term, even after surgery, *as patients continue to be at mental health risk, including for suicide*. While the causes of suicide are multifactorial, the possibility cannot be ruled out that some patients unrealistically believe that surgery(ies) solves their psychological distress."¹⁷ Whereas Rosenthal (selectively) cited Spack to support the insinuation that medical transition relieves distress, Spack instead explicitly warned against drawing exactly that conclusion.

E. Other claims

24. Rosenthal cited Green, *et al.*, (2021) and Turban, *et al.* (2021) to assert that "hormone therapy usage is significantly related to lower rates of depression and suicidality" [Rosenthal, paragraph 45]. In coming to that conclusion, Dr. Rosenthal violates a well-known principal of science: Correlation does not imply causation. That is, this very pattern is what one would predict from clinical gate-keeping: Mental health constitute exclusion criteria by clinical guidelines. Thus, samples of those receiving hormone therapy would necessarily have passed that criterion, whereas the non-medical group would contain those with already identifiable mental health concerns.

25. The plaintiff's experts indicated medical services to alleviate mental health distress; however, people with gender dysphoria continue to experience those mental health symptoms even transition, including a 19 times greater risk of death from suicide.¹⁸ It is this consistent finding in the research literature conclusion that yielded clinical guidelines repeatedly to indicate that mental health issues should be resolved *before* any transition.

¹⁷ Spack, 2013, at 484, italics added

¹⁸ Dhejne, *et al.*, 2011.

III. Science of Gender Dysphoria and Transsexualism

26. One of the most widespread public misunderstandings about transsexualism and people with gender dysphoria is that all cases of gender dysphoria represent the same phenomenon; however, the clinical science has long and consistently demonstrated that gender dysphoric children (cases of *early-onset* gender dysphoria) do not represent the same phenomenon as adult gender dysphoria (cases of *late-onset* gender dysphoria),¹⁹ merely attending clinics at younger ages. That is, gender dysphoric children are not simply younger versions of gender dysphoric adults. They differ in every known regard, from sexual interest patterns, to responses to treatments. A third presentation has recently become increasingly observed among people presenting to gender clinics: These cases appear to have an onset in adolescence in the absence of any childhood history of gender dysphoria. Such cases have been called adolescent-onset or “rapid-onset” gender dysphoria (ROGD).

27. In the context of the present proceedings, the adult-onset phenomenon would not seem relevant; however, very many public misunderstandings and expert misstatements come from misattributing evidence or personal experience from one of these types to the other. For example, there exist only very few cases of transition regret among *adult* transitioners, whereas the research has unanimously shown that the majority of children with gender dysphoria desist—that is, they cease to experience such dysphoria by or during puberty. A brief summary of the adult-onset phenomenon is therefore included here to facilitate distinguishing features which are unique to each type of gender dysphoria.

A. Adult-Onset Gender Dysphoria

28. People with adult-onset gender dysphoria typically attend clinics requesting transition services in mid-adulthood, usually in their 30s or 40s. Such individuals are nearly exclusively male.²⁰ They typically report being sexually

¹⁹ Blanchard, 1985.

²⁰ Blanchard, 1990, 1991.

attracted to women and sometimes to both men and women. Some cases profess asexuality, but very few indicate any sexual interest in or behavior involving men.²¹ Cases of adult-onset gender dysphoria are typically associated with a sexual interest pattern (medically, a *paraphilia*) involving themselves in female form.²²

1. Outcome Studies of Transition in Adult-Onset Gender Dysphoria

29. Clinical research facilities studying gender dysphoria have repeatedly reported low rates of regret (less than 3%) among adult-onset patients who underwent complete transition (*i.e.*, social, plus hormonal, plus surgical transition). This has been widely reported by clinics in Canada,²³ Sweden,²⁴ and the Netherlands.²⁵

30. Importantly, each of the Canadian, Swedish, and Dutch clinics for adults with gender dysphoria all performed “gate-keeping” procedures, disqualifying from medical services people with mental health or other contraindications. One would not expect the same results to emerge in the absence of such gate-keeping or when gate-keepers apply only minimal standards or cursory assessment.

2. Mental Health Issues in Adult-Onset Gender Dysphoria

31. The research evidence on mental health issues in gender dysphoria indicates it to be different between adult-onset versus adolescent-onset versus prepubescent-onset types. The co-occurrence of mental illness with gender dysphoria in adults is widely recognized and widely documented.²⁶ A research team in 2016 published a comprehensive and systematic review of all studies examining rates of mental health issues in transgender adults.²⁷ There were 38 studies in total. The review indicated that many studies were methodologically weak, but nonetheless

²¹ Blanchard, 1988.

²² Blanchard 1989a, 1989b, 1991.

²³ Blanchard, *et al.*, 1989.

²⁴ Dhejneberg, *et al.*, 2014.

²⁵ Wiepjes, *et al.*, 2018.

²⁶ See, *e.g.*, Hepp, *et al.*, 2005.

²⁷ Dhejne, *et al.*, 2016.

demonstrated (1) that rates of mental health issues among people are highly elevated both before and after transition, (2) but that rates were less elevated among those who completed transition. Analyses were not conducted in a way so as to compare the elevation in mental health issues observed among people newly attending clinics to improvement after transition. Also, several studies showed more than 40% of patients becoming “lost to follow-up.” With attrition rates that high, it is unclear to what extent the information from the available participants genuinely reflects the whole sample. The very high rate of “lost to follow-up” leaves open the possibility of considerably more negative results overall.

32. An important caution applies to interpreting these results: These very high proportions of mental health issues come from people who are attending a clinic for the first time and are undergoing assessment. Clinics serving a “gate-keeper” role divert candidates with mental health issues away from medical intervention. The side-effect of removing these people from the samples of transitioners is that if a researcher compared the average mental health of individuals coming into the clinic with the average mental health of individuals going through medical transition, then the post-transition group would appear to show a substantial improvement, even though transition had *no effect at all*: The removal of people with poorer mental health created the statistical illusion of improvement among the remaining people.

33. The long-standing and consistent finding that gender dysphoric adults have high rates of mental health issues both before and after transition and the finding that those mental health issues cause the gender dysphoria (the epiphenomenon) rather than the other way around indicate a critical point: To the extent that gender dysphoric children resemble adults, we should not expect mental health to improve as a result of transition. Mental health issues should be resolved before any transition.

B. Childhood Onset (Pre-Puberty) Gender Dysphoria

1. Prospective Studies of Childhood-Onset Gender Dysphoria Show that Most Children Desist in the “Natural Course” by Puberty

34. The large majority of childhood onset cases of gender dysphoria occur in biological males, with clinics reporting 2–6 biological male children to each female.²⁸

35. Prepubescent children (and their parents) have been approaching mental health professionals for help with their unhappiness with their sex and belief they would be happier living as the other for many decades. Projects following-up and reporting on such cases began being published in the 1970s, with subsequent generations of research employing increasingly sophisticated methods studying the outcomes of increasingly large samples. In total, there have now been 11 such outcomes studies, listed as Appendix 2.

36. In sum, despite coming from a variety of countries, conducted by a variety of labs, using a variety of methods, all spanning four decades, every study without exception has come to the identical conclusion: Among prepubescent children who feel gender dysphoric, the majority cease to want to be the other gender over the course of puberty—ranging from 61–88% desistance across the large, prospective studies. Such cases are often referred to as “desisters,” whereas children who continue to feel gender dysphoria are often called “persisters.”

37. Notably, in most cases, these children were receiving professional psychosocial support across the study period aimed not at affirming cross-gender identification, but at resolving stressors and issues potentially interfering with desistance. While beneficial to these children and their families, the inclusion of therapy in the study protocol represents a complication for the interpretation of the results: That is, it is not possible to know to what extent the observed outcomes (predominant desistance, with a small but consistent occurrence of persistence) were

²⁸ Cohen-Kettenis, *et al.*, 2003; Steensma, *et al.*, 2018; Wood, *et al.*, 2013.

influenced by the psychosocial support, or would have emerged regardless. It can be concluded only that prepubescent children who suffer gender dysphoria and receive psychosocial support focused on issues other than “affirmation” of cross-gender identification do in fact desist in suffering from gender dysphoria, at high rates, over the course of puberty.

38. While the absolute number of those who present as prepubescent children with gender dysphoria and “persist” through adolescence is very small in relation to the total population, persistence in some subjects was observed in each of these studies. Thus, the clinician cannot take either outcome for granted.

39. It is because of this long-established and invariably consistent research finding that desistance is probable, but not inevitable, that the “watchful waiting” method became the standard approach for assisting gender dysphoric children. The balance of potential risks to potential benefits is very different for groups likely to desist versus groups unlikely to desist: If a child is very likely to persist, then taking on the risks of medical transition might be more worthwhile than if that child is very likely to desist in transgender feelings.

40. The consistent observation of high rates of desistance among pre-pubertal children who present with gender dysphoria demonstrates a pivotally important—yet often overlooked—feature: because gender dysphoria so often desists on its own, clinical researchers cannot assume that therapeutic intervention cannot facilitate or speed desistance for at least some patients. Such is an empirical question, and there has not yet been any such study.

41. It is also important to note that research has not yet identified any reliable procedure for discerning which children who present with gender dysphoria will persist, as against the majority who will desist, absent transition and “affirmation.” Such a method would be valuable, as the more accurately that potential persisters can be distinguished from desisters, the better the risks and benefits of options can

be weighted. Such “risk prediction” and behavioral “test construction” are standard components of applied statistics in the behavioral sciences. Multiple research teams have reported that, on average, groups of persisters are somewhat more gender non-conforming than desisters, but not so different as to usefully predict the course of a particular child.²⁹

42. In contrast, a single research team (the aforementioned Olson group) claimed the opposite, asserting that they developed a method of distinguishing persisters from desisters, using a single composite score representing a combination of children’s “peer preference, toy preference, clothing preference, gender similarity, and gender identity.”³⁰ The reported a statistical association (mathematically equivalent to a correlation) between that composite score and the probability of persistence. As they indicated, “Our model predicted that a child with a gender-nonconformity score of .50 would have roughly a .30 probability . . . of socially transitioning. By contrast, a child with gender-nonconformity score of .75 would have roughly a .48 probability.”³¹ Although the Olson team declared that “social transitions may be predictable from gender identification and preferences,”³² their actual results suggest the opposite: The gender-nonconforming group who went on to transition (socially) had a mean composite score of .73 (which is less than .75), and the gender-nonconforming group who did not transition had a mean composite score of .61, also less than .75.³³ Both of those are lower than the value of .75, so both of those would be more likely than not to desist, rather than to proceed to transition. That is, Olson’s model does not distinguish likely from unlikely to transition; rather, it distinguishes unlikely from even less likely to transition.

43. Although it remains possible for some future finding to yield a method to

²⁹ Singh, *et al.* (2021); Steensma *et al.*, 2013.

³⁰ Rae, *et al.*, 2019, at 671.

³¹ Rae, *et al.*, 2019, at 673.

³² Rae, *et al.*, 2019, at 669.

³³ Rae, *et al.*, 2019, Supplemental Material at 6, Table S1, bottom line.

identify with sufficient accuracy which gender dysphoric children will persist, there does not exist such a method at the present time. Moreover, in the absence of long-term follow-up, it cannot be known what proportions come to regret having transitioned and then *detransition*. Because only a minority of gender dysphoric children persist in feeling gender dysphoric in the first place, “transition-on-demand” increases the probably of unnecessary transition and unnecessary medical risks.

2. “Watchful Waiting” and “The Dutch Approach”

44. It was this state of the science—that the majority of prepubescent children will desist in their feelings of gender dysphoria and that we lack an accurate method of identifying which children will persist—that led to the development of a clinical approach, often called “The Dutch Approach” (referring to The Netherlands clinic where it was developed) including “Watchful Waiting” periods. Internationally, the Dutch Approach is currently the most widely respected and utilized method for treatment of children who present with gender dysphoria.

45. The purpose of these methods was to compromise the conflicting needs among: clients’ desires upon assessment, the long-established and repeated observation that those preferences will change in the majority of (but not all) childhood cases, and that cosmetic aspects of medical transition are perceived to be better when they occur earlier rather than later.

46. The Dutch Approach (also called the “Dutch Protocol”) was developed over many years by the Netherlands’ child gender identity clinic, incorporating the accumulating findings from their own research as well as those reported by other clinics working with gender dysphoric children. They summarized and explicated the approach in their peer-reviewed report, *Clinical management of gender dysphoria in children and adolescents: The Dutch Approach* (de Vries & Cohen-Kettenis, 2012). The components of the Dutch Approach are:

- no social transition at all considered before age 12 (watchful waiting

period),

- no puberty blockers considered before age 12,
- cross-sex hormones considered only after age 16, and
- resolution of mental health issues before any transition.

47. For youth under age 12, “the general recommendation is watchful waiting and carefully observing how gender dysphoria develops in the first stages of puberty.”³⁴

48. The age cut-offs of the Dutch Approach authors were not based on any research demonstrating their superiority over other potential age cut-off’s. Rather, they were chosen to correspond to ages of consent to medical procedures under Dutch law. But whatever their original rationale, the data from this clinic simply contains no information about safety or efficacy of these measures at younger ages.

49. The authors of the Dutch Approach repeatedly and consistently emphasize the need for extensive mental health assessment, including clinical interviews, formal psychological testing with validated psychometric instruments, and multiple sessions with the child and the child’s parents.

50. Within the Dutch approach, there is no social transition before age twelve. That is, social affirmation of the new gender may not begin until age 12—as desistance is less likely to occur past that age. “Watchful Waiting” refers to a child’s developmental period up to that age. Watchful waiting does not mean do nothing but passively observe the child. Such children and families typically present with substantial distress involving both gender and non-gender issues. It is during the watchful waiting period that a child (and other family members as appropriate) would undergo therapy, resolving other issues which may be exacerbating psychological stress or dysphoria. As noted by the Dutch clinic, “[T]he adolescents in this study received extensive family or other social support . . . [and they] were all regularly seen by one of the clinic’s psychologists or psychiatrists.”³⁵ One is actively treating

³⁴ de Vries & Cohen-Kettenis, 2012, at 301.

³⁵ de Vries, *et al.*, 2011, at 2280-81.

the person, while carefully “watching” the dysphoria.

51. The inclusion of psychotherapy and support during the watchful waiting period is, clinically, a great benefit to the gender dysphoric children and their parents. The inclusion of psychotherapy and support poses a scientific complication, however: It becomes difficult to know to what extent the outcomes of these cases might be related to receiving psychotherapy received versus being “spontaneous” desistance, which would have occurred on its own anyway. This situation is referred to in science as a “confound.”

3. Studies of Transition Outcomes: Overview

52. Very many strong claims have appeared in the media and on social media asserting that transition results in improved mental health or, contradictorily, in decreased mental health. In the highly politicized context of gender and transgender research, many authors have cited only the findings which appear to support one side, cherry-picking from the complete set of research reports. Seemingly contradictory findings are common in science with on-going research projects. When considered together, however, the full set of relevant reports show that a coherent pattern and conclusion has emerged over time, as detailed in the following sections. Initial optimism was suggested by reports of improvements in mental health.³⁶ Upon continued analysis, these seeming successes turned out to be illusory, however: The Bränström and Pachankis (2019) finding has been retracted.³⁷ The greater mental health among transitioners reported by Costa, *et al.* (2015) was noted to be because the control group consisted of cases excluded from hormone eligibility exactly because they showed poor mental health to begin with.³⁸ The improvements reported by the de Vries studies from the Dutch Clinic themselves appear genuine; however, because that clinic also provides psychotherapy to all cases receiving puberty-blockers, it

³⁶ Bränström & Pachankis 2019; Costa, *et al.*, 2015; de Vries, *et al.*, 2011; de Vries, *et al.*, 2014.

³⁷ Kalin, 2020.

³⁸ Biggs, 2019.

remains entirely plausible that the psychotherapy and not the puberty blockers caused the improvements.³⁹ New studies continue to appear an accelerating rate, repeatedly reporting deteriorations or lacks of improvement in mental health⁴⁰ or lack of improvement beyond psychotherapy alone,⁴¹ and other studies continue to report on only the combined effect of both psychotherapy and hormone treatment together.⁴²

**a. Outcomes of The Dutch Approach (studies from before 2017):
Mix of positive, negative, and neutral outcomes**

53. The research confirms that some, but not all, adolescents improve on some, but not all, indicators of mental health and that those indicators are inconsistent across studies. Thus, the balance of potential benefits to potential risks differs across cases, and thus suggests different courses of treatment across cases.

54. The Dutch clinical research team followed up 70 youth undergoing puberty suppression at their clinic.⁴³ The youth improved on several variables upon follow-up as compared to pre-suppression measurement, including depressive symptoms and general functioning. No changes were detected in feelings of anxiety or anger or in gender dysphoria as a result of puberty suppression; however, natal females using puberty suppression suffered *increased* body dissatisfaction both with their secondary sex characteristics and with nonsexual characteristics.⁴⁴

55. As the report authors noted, while it is possible that the improvement on some variables was due to the puberty-blockers, it is also possible that the improvement was due to the mental health support, and it is possible that the improvement occurred only on its own with natural maturation. So any conclusion that puberty blockers improved the mental health of the treated children is not

³⁹ Biggs, 2020.

⁴⁰ Carmichael, *et al.*, 2021; Hisle-Gorman, *et al.*, 2021; Kaltiala, *et al.*, 2020.

⁴¹ Achille, *et al.*, 2020.

⁴² Kuper, *et al.*, 2020; van der Miesen, *et al.*, 2020, at 703.

⁴³ de Vries, *et al.* 2011.

⁴⁴ Biggs, 2020.

justified by the data. Because this study did not include a control group (another group of adolescents matching the first group, but *not* receiving medical or social support), these possibilities cannot be distinguished from each other, representing a confound. The authors of the study were explicit in noting this themselves: “All these factors may have contributed to the psychological well-being of these gender dysphoric adolescents.”⁴⁵

56. The authors were careful not to overstate the implications of their results, “We *cautiously* conclude that puberty suppression *may be* a valuable *element* in clinical management of adolescent gender dysphoria.”⁴⁶

57. Costa, *et al.* (2015) reported on preliminary outcomes from the Tavistock and Portman NHS Foundation Trust clinic in the UK. They compared the psychological functioning of one group of youth receiving psychological support with a second group receiving both psychological support as well as puberty blocking medication. Both groups improved in psychological functioning over the course of the study, but no statistically significant differences between the groups was detected at any point.⁴⁷ As those authors concluded, “Psychological support and puberty suppression were both associated with an improved global psychosocial functioning in GD adolescence. Both these interventions may be considered effective in the clinical management of psychosocial functioning difficulties in GD adolescence.”⁴⁸ Because psychological support does not pose the physical health risks that hormonal interventions or surgery does (such as loss of reproductive function), one cannot justify taking on the greater risks of social transition, puberty blockers or surgery without evidence of such treatment producing superior results. Such evidence does not exist.

b. Clinicians and advocates have invoked the Dutch Approach

⁴⁵ de Vries, *et al.* 2011, at 2281.

⁴⁶ de Vries, *et al.* 2011, at 2282, italics added.

⁴⁷ Costa, *et al.*, at 2212 Table 2.

⁴⁸ Costa, *et al.*, at 2206.

while departing from its protocols in important ways.

58. The reports of partial success contained in de Vries, *et al.* 2011 called for additional research, both to confirm those results and to search for ways to maximize beneficial results and minimize negative outcomes. Instead, many other clinics and clinicians proceeded on the basis of the positives only, broadened the range of people beyond those represented in the research findings, and removed the protections applied in the procedures that led to those outcomes. Many clinics and individual clinicians have reduced the minimum age for transition to 10 instead of 12. While the Dutch Protocol involves interdisciplinary teams of clinicians, many clinics now rely on a single assessor, in some cases one without adequate professional training in childhood and adolescent mental health. Comprehensive, longitudinal assessments (*e.g.*, one and a half years⁴⁹) became approvals after one or two assessment sessions. Validated, objective measures of youths' psychological functioning were replaced with clinicians' subjective (and first) opinions, often reflecting only the clients' own self-report. Systematic recordings of outcomes, so as to allow for detection and correction of clinical deficiencies, were eliminated.

59. Notably, Dr. Thomas Steensma, central researcher of the Dutch clinic, has decried other clinics for "blindly adopting our research" despite the indications that those results may not actually apply: "We don't know whether studies we have done in the past are still applicable to today. Many more children are registering, and also a different type."⁵⁰ Steensma opined that "every doctor or psychologist who is involved in transgender care should feel the obligation to do a good pre- and post-test." But few if any are doing so.

c. Studies by other clinicians in other countries have failed to reliably replicate the positive components of the results reported by the Dutch clinicians in de Vries et al. 2011.

60. The indications of potential benefit from puberty suppression in at least

⁴⁹ de Vries, *et al.*, 2011.

⁵⁰ Tetelepta, 2021.

some cases has led some clinicians to attempt to replicate the positive aspects of those findings. These efforts have not succeeded.

61. The Tavistock and Portman clinic in the U.K. recently released its findings, attempting to replicate the outcomes reported by the Dutch clinic.⁵¹ Study participants were ages 12–15 (Tanner stages 3 for natal males, Tanner 2 for natal females) and were repeatedly tested before beginning puberty-blocking medications and then every six months thereafter. Cases exhibiting serious mental illnesses (*e.g.*, psychosis, bipolar disorder, anorexia nervosa, severe body-dysmorphic disorder unrelated to gender dysphoria) were excluded. Relative to the time point before beginning puberty suppression, there were *no* significant changes in any psychological measure, from either the patients’ or their parents’ perspective.

62. A multidisciplinary team from Dallas published a prospective follow-up study which included 25 youths as they began puberty suppression.⁵² (The other 123 study participants were undergoing cross-sex hormone treatment.) Interventions were administered according to “Endocrine Society Clinical Practice Guidelines.”⁵³ Their analyses found *no statistically significant changes* in the group undergoing puberty suppression on any of the nine measures of wellbeing measured, spanning tests of body satisfaction, depressive symptoms, or anxiety symptoms.⁵⁴ (Although the authors reported detecting some improvements, these were only found when the large group undergoing cross-sex hormone treatment were added in.) Although the Dutch Approach includes age 12 as a minimum for puberty suppression treatment, this team provided such treatment beginning at age 9.8 years (full range: 9.8–14.9 years).⁵⁵

63. Achille, *et al.* (2020) at Stony Brook Children’s Hospital in New York treated a sample of 95 youth with gender dysphoria, providing follow-up data on 50

⁵¹ Carmichael, *et al.*, 2021.

⁵² Kuper, *et al.*, 2020, at 5.

⁵³ Kuper, *et al.*, 2020, at 3, referring to Hembree, *et al.*, 2017.

⁵⁴ Kuper, *et al.*, 2020, at Table 2.

⁵⁵ Kuper, *et al.*, 2020, at 4.

of them. (The report did not indicate how these 50 were selected from the 95.) As well as receiving puberty blocking medications, “Most subjects were followed by mental health professionals. Those that were not were encouraged to see a mental health professional.”⁵⁶ The puberty blockers themselves “were introduced in accordance with the Endocrine Society and the WPATH guidelines.”⁵⁷ Upon follow-up, some incremental improvements were noted; however, after statistically adjusting for psychiatric medication and engagement in counselling, “*most predictors did not reach statistical significance.*”⁵⁸ That is, puberty blockers did not improve mental health any more than did mental health care on its own.

64. In a recent update, the Dutch clinic reported continuing to find improvement in transgender adolescents’ psychological functioning, reaching age-typical levels, “after the start of specialized transgender care involving puberty suppression.”⁵⁹ Unfortunately, because the transgender care method of that clinic involves both psychosocial support and puberty suppression, it cannot be known which of those (or their combination) is driving the improvement. Also, the authors indicate that the changing demographic and other features among gender dysphoric youth might have caused the treated group to differ from the control group in unknown ways. As the study authors themselves noted, “The present study can, therefore, not provide evidence about the direct benefits of puberty suppression over time and long-term mental health outcomes.”⁶⁰

65. It has not yet been determined why the successful outcomes reported by the Dutch child gender clinic a decade ago failed to emerge when applied by others more recently. It is possible that:

- (1) The Dutch Approach itself does *not* work and that their originally successful results were a fluke;

⁵⁶ Achille, *et al.*, 2020, at 2.

⁵⁷ Achille, *et al.*, 2020, at 2.

⁵⁸ Achille, *et al.*, 2020, at 3 (*italics added*).

⁵⁹ van der Miesen, *et al.*, 2020, at 699.

⁶⁰ van der Miesen, *et al.*, 2020, at 703.

- (2) The Dutch Approach *does* work, but only in the Netherlands, with local cultural, genetic, or other unrecognized factors that do not generalize to other countries;
- (3) The Dutch Approach itself *does* work, but other clinics and individual clinicians are removing safeguards and adding short-cuts to the approach, and those changes are hampering success.
- (4) The Dutch Approach *does* work, but the cause of the improvement is the psychosocial support, rather than any medical intervention, which other clinics are *not* providing.

66. The failure of other clinics to repeat the already very qualified success of the Dutch clinic demonstrates the need for still greater caution before endorsing transition and the greater need to resolve potential mental health obstacles before doing so.

4. Mental Health Issues in Childhood-Onset Gender Dysphoria

67. As shown by the outcomes studies, there is no statistically significant evidence that transition reduces the presence of mental illness among transitioners. As shown repeatedly by clinical guidelines from multiple professional associations, mental health issues are expected or required to be resolved *before* undergoing transition. The reasoning behind these conclusions is that children may be expressing gender dysphoria, not because they are experiencing what gender dysphoric adults report, but because they mistake what their experiences indicate or to what they might lead. For example, a child experiencing depression from social isolation might develop hope—and the unrealistic expectation—that transition will help them fit in, this time as and with the other sex.

68. If a child undergoes transition, discovering only then that their mental health or social situations will not in fact change, the medical risks and side-effects (such as sterilization) will have been borne for no reason. If, however, a child resolves the mental health issues first with the gender dysphoria resolving with it (which the research literature shows to be the case in the large majority), then the child need not undergo transition at all, but yet still retains the opportunity to do so later.

69. Elevated rates of multiple mental health issues among gender dysphoric

children are reported throughout the research literature. A formal analysis of children (ages 4–11) undergoing assessment at the Dutch child gender clinic showed 52% fulfilled criteria for a DSM axis-I disorder.⁶¹ A comparison of the children attending the Canadian versus Dutch child gender dysphoria clinic showed only few differences between them, but a large proportion in both groups were diagnosable with clinically significant mental health issues. Results of standard assessment instruments (Child Behavior Check List, or CBCL) demonstrated that the average score was in the clinical rather than healthy range, among children in both clinics.⁶² When expressed as percentages, among 6–11-year-olds, 61.7% of the Canadian and 62.1% of the Dutch sample were in the clinical range.

70. A systematic, comprehensive review of all studies of Autism Spectrum Disorders (ASDs) and Attention-Deficit Hyperactivity Disorder (ADHD) among children diagnosed with gender dysphoria was recently conducted. It was able to identify a total of 22 studies examining the prevalence of ASD or ADHD in youth with gender dysphoria. Studies reviewing medical records of children and adolescents referred to gender clinics showed 5–26% to have been diagnosed with ASD.⁶³ Moreover, those authors gave specific caution on the “considerable overlap between symptoms of ASD and symptoms of gender variance, exemplified by the subthreshold group which may display symptoms which could be interpreted as either ASD or gender variance. Overlap between symptoms of ASD and symptoms of GD may well confound results.”⁶⁴ When two or more issues are present at the same time (in this case, gender dysphoria present at the same time as ADHD or ASD), researchers cannot distinguish when a result is associated with or caused by the issue of interest (gender dysphoria itself) or one of the side issues, called *confounds* (ADHD or ASD,

⁶¹ Wallien, *et al.*, 2007.

⁶² Cohen-Kettenis, *et al.*, 2003, at 46.

⁶³ Thrower, *et al.*, 2020.

⁶⁴ Thrower, *et al.*, 2020, at 703.

in the present case).⁶⁵ The rate of ADHD among children with GD was 8.3–11%. Conversely, in data from children (ages 6–18) with Autism Spectrum Disorders (ASDs) show they are more than seven times more likely to have parent-reported “gender variance.”⁶⁶

C. Adolescent-Onset Gender Dysphoria

1. Features of Adolescent-Onset Gender Dysphoria

71. In the social media age, a third profile has recently begun to present to clinicians or socially, characteristically distinct from the previously identified ones.⁶⁷ Unlike adult-onset gender dysphoria and unlike childhood-onset, this group is predominately biologically female. This group first presents in adolescence, but lacks the history of cross-gender behavior in childhood like the childhood-onset cases have. It is this feature which led to the term Rapid Onset Gender Dysphoria (ROGD).⁶⁸ The majority of cases appear to occur within clusters of peers and in association with increased social media use⁶⁹ and especially among people with autism or other neurodevelopmental or mental health issues.⁷⁰

72. It cannot be easily determined whether the self-reported gender dysphoria is a result of other underlying issues or if those mental health issues are the result of the stresses of being a sexual minority, as some writers are quick to assume.⁷¹ (The science of the *Minority Stress Hypothesis* appears in its own section.) Importantly, and unlike other presentations of gender dysphoria, people with rapid-onset gender dysphoria often (47.2%) experienced *declines* rather than improvements in mental health when they publicly acknowledged their gender status.⁷² Although long-term outcomes have not yet been reported, these distinctions demonstrate that one cannot

⁶⁵ Cohen-Kettenis *et al.*, 2003, at 51; Skelly *et al.*, 2012.

⁶⁶ Janssen, *et al.*, 2016.

⁶⁷ Kaltiala-Heino, *et al.*, 2015; Littman, 2018.

⁶⁸ Littman, 2018.

⁶⁹ Littman, 2018.

⁷⁰ Kaltiala-Heino, *et al.*, 2015; Littman, 2018; Warrier, *et al.*, 2020.

⁷¹ Boivin, *et al.*, 2020.

⁷² Biggs, 2020; Littman, 2018.

apply findings from the other types of gender dysphoria to this type. That is, in the absence of evidence, researchers cannot assume that the pattern found in childhood-onset or adult-onset gender dysphoria also applies to rapid-onset (aka adolescent-onset) gender dysphoria. The group differences already observed argue against the conclusion that any given feature would be present, in general, throughout all types of gender dysphoria.

2. Prospective Studies of Social Transition and Puberty Blockers in Adolescence

73. There do not yet exist prospective outcomes studies either for social transition or for medical interventions for people whose gender dysphoria began in adolescence. That is, instead of taking a sample of individuals and following them forward over time (thus permitting researchers to account for people dropping out of the study, people misremembering the order of events, etc.), all studies have thus far been *retrospective*. It is not possible for such studies to identify what factors caused what outcomes. No study has yet been organized in such a way as to allow for an analysis of the adolescent-onset group, as distinct from childhood-onset or adult-onset cases. Many of the newer clinics (not the original clinics which systematically tracked and reported on their cases' results) fail to distinguish between people who had childhood-onset gender dysphoria and have aged into adolescence and people whose onset was not until adolescence. Similarly, there are clinics failing to distinguish people who had adolescent-onset gender dysphoria and aged into adulthood from adult-onset gender dysphoria. Studies selecting groups according to their current age instead of their ages of onset can produce only confounded results, representing unclear mixes according to how many of each type of case wound up in the final sample.

3. Mental Illness in Adolescent-Onset Gender Dysphoria

74. In 2019, a Special Section of the *Archives of Sexual Behavior* was published:

“Clinical Approaches to Adolescents with Gender Dysphoria.” It included this brief yet thorough summary of rates of mental health issues among adolescents expressing gender dysphoria by Dr. Aron Janssen of the Department of Child and Adolescent Psychiatry of New York University.⁷³ The literature varies in the range of percentages of adolescents with co-occurring disorders. The range for depressive symptoms ranges was 6–42%,⁷⁴ with suicide attempts ranging 10 to 45%.⁷⁵ Self-injurious thoughts and behaviors range 14–39%.⁷⁶ Anxiety disorders and disruptive behavior difficulties including Attention Deficit/Hyperactivity Disorder are also prevalent.⁷⁷ Gender dysphoria also overlaps with Autism Spectrum Disorder.⁷⁸

75. Of particular concern in the context of adolescent onset gender dysphoria is *Borderline Personality Disorder* (BPD). The DSM-5-TR criteria for BPD are⁷⁹:

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationship characterized by alternating between extremes of idealization and devaluation.
3. *Identity disturbance: markedly and persistently unstable self-image or sense of self.*
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. *Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behavior.*
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

⁷³ Janssen, *et al.*, 2019.

⁷⁴ Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013; Wallien, *et al.*, 2007.

⁷⁵ Reisner, *et al.*, 2015.

⁷⁶ Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013.

⁷⁷ de Vries, *et al.*, 2011; Mustanski, *et al.*, 2010; Wallien, *et al.*, 2007.

⁷⁸ de Vries, *et al.*, 2010; Jacobs, *et al.*, 2014; Janssen, *et al.*, 2016; May, *et al.*, 2016; Strang, *et al.*, 2014, 2016.

⁷⁹ American Psychiatric Association, 2022, pp. 752–753, italics added.

7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

(Italics added.)

76. It is increasingly hypothesized that very many cases appearing to be adolescent-onset gender dysphoria are actually cases of BPD.⁸⁰ That is, some people may be misinterpreting their experiences to represent a gender identity issue, when it instead represents the “identity disturbance” noted in symptom Criterion 3. Like adolescent-onset gender dysphoria, BPD begins to manifest in adolescence, is substantially more common among biological females than males, and occurs in 2–3% of the population, rather than 1-in-5,000 people (*i.e.*, 0.02%). Thus, if even only a portion of people with BPD had an ‘identity disturbance’ that focused on gender identity and were mistaken for transgender, they could easily overwhelm the number of genuine cases of gender dysphoria.

77. A primary cause for concern is symptom Criterion 5: recurrent suicidality. Regarding the provision of mental health care, this is a crucial distinction: A person with BPD going undiagnosed will not receive the appropriate treatments (the currently most effective of which is Dialectical Behavior Therapy). A person with a cross-gender identity would be expected to feel relief from medical transition, but someone with BPD would not: The problem was not about *gender* identity, but about having an *unstable* identity. Moreover, after a failure of medical transition to provide relief, one would predict for these people increased levels of hopelessness and increased risk of suicidality. One would predict also that misdiagnoses would occur more often if one reflexively dismissed or discounted symptoms of BPD as responses to “minority stress.” The Minority Stress Hypothesis is discussed in its own section

⁸⁰ *E.g.*, Anzani, *et al.*, 2020; Zucker, 2019.

herein.

78. Regarding research, there have now been several attempts to document rates of suicidality among gender dysphoric adolescents (reviewed in its own section herein). The scientific concern presented by BPD is that it poses a potential confound: samples of gender dysphoric adolescents could appear to have elevated rates of suicidality, not because of the gender dysphoria (or transphobia in society), but because of the number of people with BPD in the sample.

IV. Other Scientific Claims Assessed

A. Conversion Therapy

79. Activists and social media increasingly, but erroneously, apply the term “conversion therapy” moving farther and farther from what the research has reported. “Conversion therapy” (or “reparative therapy” and other names) was the attempt to change a person’s sexual orientation; however, with the public more frequently accustomed to “LGB” being expanded to “LGBTQ+”, the claims relevant only to sexual orientation are being misapplied to gender identity. The research has repeatedly demonstrated that once one explicitly acknowledges being gay or lesbian, this is only very rarely are mistaken. That is entirely unlike gender identity, wherein the great majority of children who declare cross-gender identity cease to do so by puberty, as shown unanimously by every follow-up study ever published. As the field grows increasingly polarized, any therapy failing to provide affirmation-on-demand is mislabeled “conversion therapy.”⁸¹ Indeed, even actions of non-therapists, unrelated to any therapy have been labelled conversion therapy, including the prohibition of biological males competing on female teams.⁸²

B. Assessing Claims of Suicidality

80. In the absence of scientific evidence associating improvement with

⁸¹ D’Angelo, *et al.*, 2021.

⁸² Turban, 2021, March 16.

transition among youth, demands for transition are increasingly accompanied by hyperbolic warnings of suicide should there be delay or obstacle to affirmation-on-demand. Social media circulate claims of extreme suicidality accompanied by declarations that “I’d rather have a trans daughter than a dead son.” Such claims convey only grossly misleading misrepresentations of the research literature, however.

81. Despite that the media treat them as near synonyms, suicide and suicidality are distinct phenomena. They represent different behaviors with different motivations, with different mental health issues, and with differing clinical needs. *Suicide* refers to completed suicides and the sincere intent to die. It is substantially associated with impulsivity, using more lethal means, and being a biological male.⁸³ *Suicidality* refers to parasuicidal behaviors, including suicidal ideation, threats, and gestures. These typically represent cries for help rather than an intent to die and are more common among biological females. Suicidal threats can indicate any of many problems or represent emotional blackmail, as typified in “If you leave me, I will kill myself.” Professing suicidality is also used for attention-seeking or for the support or sympathy it evokes from others, indicating distress much more frequently than an intent to die.

82. The scientific study of suicide is inextricably linked to that of mental illness. For example, as noted in the preceding, suicidality is a well-documented symptom of Borderline Personality Disorder (as are chronic identity issues), and personality disorders are highly elevated among transgender populations, especially adolescent-onset. Thus, the elevations of suicidality among gender dysphoric adolescents may not be a result of anything related to transition (or lack of transition), but to the overlap with mental illness of which suicidality is a substantial part. Conversely,

⁸³ Freeman, *et al.*, 2017.

improvements in suicidality reported in some studies may not be the result of anything related to transition, but rather to the concurrent general mental health support which is reported by the clinical reported prospective outcomes. Studies that include more than one factor at the same time without accounting for each other represent a “confound,” and it cannot be known which factor (or both) is the one causing the effects observed. That is, when a study provides both mental health services and medical transition services at the same time, it cannot be known which (or both) is what caused any changes.

83. A primary criterion for readiness for transition used by the clinics demonstrating successful transition is the absence or resolution of other mental health concerns, such as suicidality. In the popular media, however, indications of mental health concerns are instead often dismissed as an expectable result caused by Sexual Minority Stress (SMS). It is generally implied that such symptoms will resolve upon transition and integration into an affirming environment.

84. Despite that mental health issues, including suicidality, are repeatedly required by clinical standards of care to be resolved before transition, threats of suicide are instead oftentimes used as the very justification for labelling transition a ‘medical necessity’. However plausible it might seem that failing to affirm transition causes suicidality, the epidemiological evidence indicates that hypothesis to be incorrect: Suicide rates remains elevated even after complete transition, as shown by a comprehensive review of 17 studies of suicidality in gender dysphoria.⁸⁴

85. Of particular relevance in the present context is suicidality as a well-documented symptom of Borderline Personality Disorder (BPD) and that very many cases appearing to be adolescent-onset gender dysphoria actually represent cases of BPD. [See full DSM-5-TR criteria already listed herein.] That is, some people may be

⁸⁴ McNeil, *et al.*, 2017.

misinterpreting their experiencing of the broader “identity disturbance” of symptom Criterion 3 to represent a gender identity issue specifically. Like adolescent-onset gender dysphoria, BPD begins to manifest in adolescence and occurs in 2–3% of the population, rather than 1-in-5,000 people. (Thus, if even only a portion of people with BPD experienced an identity disturbance that focused on gender identity and were mistaken for transgender, they could easily overwhelm the number of genuine cases of gender dysphoria.)

86. Rates of completed suicide are elevated among post-transition transsexuals, but are nonetheless rare,⁸⁵ and BPD is repeatedly documented to be greatly elevated among sexual minorities⁸⁶. Overall, rates of suicidal ideation and suicidal attempts appear to be related—not to transition status—but to the social support received: The research evidence shows that support decreases suicidality, but that transition itself does not. Indeed, in some situations, social support was associated with increased suicide attempts, suggesting the reported suicidality may represent attempts to evoke more support.⁸⁷

C. Assessing Demands for Social Transition and Affirmation-Only or Affirmation-on-Demand Treatment in Pre-Pubertal Children.

87. Colloquially, affirmation refers broadly to any actions that treat the person as belonging to a new gender. In different contexts, that could apply to social actions (use of a new name and pronouns), legal actions (changes to birth certificates), or medical actions (hormonal and surgical interventions). That is, social transition, legal transition, and medical transition (and subparts thereof) need not, and rarely do, occur at the same time. In practice, there are cases in which a child has socially only partially transitioned, such as presenting as one gender at home and another at school or presenting as one gender with one custodial parent and another gender with

⁸⁵ Wiepjes, *et al.*, 2020.

⁸⁶ Reuter, *et al.*, 2016; Rodriguez-Seiljas, *et al.*, 2021; Zanarni, *et al.*, 2021.

⁸⁷ Bauer, *et al.*, 2015; Canetto, *et al.*, 2021.

the other parent.

88. Referring to “affirmation” as a treatment approach is ambiguous: Although often used in public discourse to take advantage of the positive connotations of the term, it obfuscates what exactly is being affirmed. This often leads to confusion, such as quoting a study of the benefits and risks of social affirmation in a discussion of medical affirmation, where the appearance of the isolated word “affirmation” refers to entirely different actions.

89. It is also an error to divide treatment approaches into affirmative versus non-affirmative. As noted already, the widely adopted Dutch Approach (and the guidelines of the multiple professional associations based on it) cannot be said to be either: It is a staged set of interventions, wherein social transition (and puberty blocking) may not begin until age 12 and cross-sex hormonal and other medical interventions, later.

90. Formal clinical approaches to helping children expressing gender dysphoria employ a gate-keeper model, with decision trees to help clinicians decide when and if the potential benefits of affirmation of the new gender would outweigh the potential risks of doing so. Because the gate-keepers and decision-trees generally include the possibility of affirmation in at least some cases, it is misleading to refer to any one approach as “the affirmation approach.” The most extreme decision-tree would be accurately called *affirmation-on-demand*, involving little or no opportunity for children to explore at all whether the distress they feel is due to some other, less obvious, factor, whereas more moderate gate-keeping would endorse transition only in select situations, when the likelihood of regretting transition is minimized.

91. Many outcomes studies have been published examining the results of gate-keeper models, but no such studies have been published regarding *affirmation-on-demand* with children. Although there have been claims that *affirmation-on-demand* causes mental health or other improvement, these have been the result only of

“retrospective” rather than “prospective” studies. That is, such studies did not take a sample of children and follow them up over time, to see how many dropped out altogether, how many transitioned successfully, and how many transitioned and regretted it or detransitioned. Rather, such studies took a sample of successfully transitioned adults and asked them retrospective questions about their past. In such studies, it is not possible to know how many other people dropped out or regretted transition, and it is not possible to infer causality from any of the correlations detected, despite authors implying and inferring causality.

D. Assessing the “Minority Stress Hypothesis”

92. The elevated levels of mental health problems among lesbian, gay, and bisexual populations is a well-documented phenomenon, and the idea that it is caused by living within a socially hostile environment is called the *Minority Stress Hypothesis*.⁸⁸ The association is not entirely straight-forward, however. For example, although lesbian, gay, and bisexual populations are more vulnerable to suicide ideation overall, the evidence specifically on adult lesbian and bisexual women is unclear. Meyer did not include transgender populations in originating the hypothesis, and it remains a legitimate question to what extent and in what ways it might apply to gender identity.

93. Minority stress is associated, in large part, with being a visible minority. There is little evidence that transgender populations show the patterns suggested by the hypothesis. For example, the minority stress hypothesis would predict differences according to how visibly a person is discernable as a member of the minority, which often changes greatly upon transition. Biological males who are very effeminate stand out throughout childhood, but in some cases can successfully blend in as adult females; whereas the adult-onset transitioners blend in very much as heterosexual cis-gendered males during their youth and begin visibly to stand out in adulthood,

⁸⁸ Meyer, 2003.

only for the first time.

94. Also suggesting minority stress cannot be the full story is that the mental health symptoms associated with minority stress do not entirely correspond with those associated with gender dysphoria. The primary symptoms associated with minority stress are depressive symptoms, substance use, and suicidal ideation.⁸⁹ The symptoms associated with gender dysphoria indeed include depressive symptoms and suicidal ideation, but also include anxiety symptoms, Autism Spectrum Disorders, and personality disorders.

V. Assessing Statements from Professional Associations

A. Understanding the Value of Statements from Professional Associations

95. The value of position statements from professional associations should be neither over- nor under-estimated. In the ideal, an organization of licensed health care professionals would convene a panel of experts who would systematically collect all the available evidence about an issue, synthesizing it into recommendations or enforceable standards for clinical care, according to the quality of the evidence for each alternative. For politically neutral issues, with relevant expertise contained among association members, this ideal can be readily achievable. For controversial issues with no clear consensus, the optimal statement would summarize each perspective and explicate the strengths and weaknesses of each, providing relatively reserved recommendations and suggestions for future research that might resolve the continuing questions. Several obstacles can hinder that goal, however. Committees within professional organizations are typically volunteer activities, subject to the same internal politics of all human social structures. That is, committee members are not necessarily committees of experts on a topic—they are often committees of generalists handling a wide variety of issues or members of an interest group who

⁸⁹ Meyer, 2003.

feel strongly about political implications of an issue, instead of scientists engaged in the objective study of the topic.

96. Thus, documents from professional associations may represent required standards, the violation of which may merit sanctions, or may represent only recommendations or guidelines. A document may represent the views of an association's full membership or only of the committee's members (or majorities thereof). Documents may be based on systematic, comprehensive reviews of the available research or selected portions of the research. In sum, the weight best placed on any association's statement is the amount by which that association employed evidence versus other considerations in its process.

B. Misrepresentations of statements of professional associations.

97. In the presently highly politicized context, official statements of professional associations have been widely misrepresented. In preparing the present report, I searched the professional research literature for documentation of statements from these bodies and from my own files, for which I have been collecting such information for many years. I was able to identify statements from six such organizations. Although not strictly a medical association, the World Professional Association for Transgender Health (WPATH) also distributed a set of guidelines in wide use and on which other organizations' guidelines are based.

98. Notably, despite that all these medical associations reiterate the need for mental health issues to be resolved before engaging in medical transition, only the AACAP members have medical training in mental health. The other medical specialties include clinical participation with this population, but their assistance in transition generally assumes the mental health aspects have already been assessed and treated beforehand.

1. World Professional Association for Transgender Health (WPATH)

99. The WPATH standards as they relate to prepubescent children begin with the acknowledgement of the known rates of desistance among gender dysphoric children:

[I]n follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6–23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12–27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).⁹⁰

100. That is, “In most children, gender dysphoria will disappear before, or early in, puberty.”⁹¹

101. Although WPATH does not refer to puberty blocking medications as “experimental,” the document indicates the non-routine, or at least inconsistent availability of the treatment:

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment—starting with GnRH analogues to suppress puberty in the first Tanner stages—differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Deleamarre, van de Waal & Cohen-Kettenis, 2006; Zucker et al., [2012]).⁹²

102. WPATH neither endorses nor proscribes social transitions before puberty, instead recognizing the diversity among families’ decisions:

Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood.⁹³

103. It does caution, however, “Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria.”⁹⁴

2. Endocrine Society (ES)

⁹⁰ Coleman, *et al.*, 2012, at 172.

⁹¹ Coleman, *et al.*, 2012, at 173.

⁹² Coleman, *et al.*, 2012, at 173.

⁹³ Coleman, *et al.*, 2012, at 176.

⁹⁴ Coleman, *et al.*, 2012, at 176 (quoting Drummond, *et al.*, 2008; Wallien & Cohen-Kettenis, 2008).

104. The 150,000-member Endocrine Society appointed a nine-member task force, plus a methodologist and a medical writer, who commissioned two systematic reviews of the research literature and, in 2017, published an update of their 2009 recommendations, based on the best available evidence identified. The guideline was co-sponsored by the American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Paediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society (PES), and the World Professional Association for Transgender Health (WPATH).

105. The document acknowledged the frequency of desistance among gender dysphoric children:

Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called “desisters”). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence. . . . In adolescence, a significant number of these desisters identify as homosexual or bisexual.⁹⁵

106. The statement similarly acknowledges inability to predict desistance or persistence, “With current knowledge, we cannot predict the psychosexual outcome for any specific child.”⁹⁶

107. Although outside their area of professional expertise, mental health issues were also addressed by the Endocrine Society, repeating the need to handle such issues before engaging in transition, “In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues.”⁹⁷ This ordering—to address mental health issues before embarking on transition—avoids relying on the unproven belief that transition will solve such issues.

⁹⁵ Hembree, *et al.*, 2017, at 3876.

⁹⁶ Hembree, *et al.*, 2017, at 3876.

⁹⁷ Hembree, *et al.*, 2017, at 3877.

108. The Endocrine Society did not endorse any affirmation-only approach. The guidelines were neutral with regard to social transitions before puberty, instead advising that such decisions be made only under clinical supervision: “We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional.”⁹⁸

109. The Endocrine Society guidelines make explicit that, after gathering information from adolescent clients seeking medical interventions and their parents, the clinician “provides correct information to prevent unrealistically high expectations [and] assesses whether medical interventions may result in unfavorable psychological and social outcomes.”⁹⁹

3. Pediatric Endocrine Society and Endocrine Society (ES/PES)

110. In 2020, the 1500-member Pediatric Endocrine Society partnered with the Endocrine Society to create and endorse a brief, two-page position statement.¹⁰⁰ Although strongly worded, the document provided no specific guidelines, instead deferring to the Endocrine Society guidelines.¹⁰¹

111. It is not clear to what extent this endorsement is meaningful, however. According to the PES, the Endocrine Society “recommendations include evidence that treatment of gender dysphoria/gender incongruence is medically necessary and should be covered by insurance.”¹⁰² However, the Endocrine Society makes neither statement. Although the two-page PES document mentioned insurance coverage four times, the only mention of health insurance by the Endocrine Society was: “If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an

⁹⁸ Hembree, *et al.*, 2017, at 3872.

⁹⁹ Hembree, *et al.*, 2017, at 3877.

¹⁰⁰ PES, online; Pediatric Endocrine Society & Endocrine Society, Dec. 2020.

¹⁰¹ Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1; Hembree, *et al.*, 2017.

¹⁰² Pediatric Endocrine Society & Endocrine Society, Dec. 2020, at 1.

antiandrogen that directly suppresses androgen synthesis or action.”¹⁰³ Despite the PES asserting it as “medically necessary,” the Endocrine Society stopped short of that. Its only use of that phrase was instead limiting: “We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient’s overall health and/or well-being.”¹⁰⁴

4. American Academy of Child & Adolescent Psychiatry (AACAP)

112. The 2012 statement of the American Academy of Child & Adolescent Psychiatry (AACAP) is not an affirmation-only policy. It notes:

Just as family rejection is associated with problems such as depression, suicidality, and substance abuse in gay youth, the proposed benefits of treatment to eliminate gender discordance in youth must be carefully weighed against such possible deleterious effects. . . . In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood, or at least until the wish to change sex is unequivocal, consistent, and made with appropriate consent.¹⁰⁵

113. The AACAP’s language repeats the description of the use of puberty blockers only as an exception: “For situations in which deferral of sex reassignment decisions until adulthood is *not clinically feasible*, one approach that has been described in case series is sex hormone suppression under endocrinological management with psychiatric consultation using gonadotropin-releasing hormone analogues.”¹⁰⁶

114. The AACAP statement acknowledges the long-term outcomes literature for gender dysphoric children: “In follow-up studies of prepubertal boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood,”¹⁰⁷ adding that “[c]linicians should be aware of current evidence on the natural course of gender

¹⁰³ Hembree, *et al.* 2017, at 3883.

¹⁰⁴ Hembree, *et al.*, 2017 at 3872, 3894.

¹⁰⁵ Adelson & AACAP, 2012, at 969.

¹⁰⁶ Adelson & AACAP, 2012, at 969 (italics added).

¹⁰⁷ Adelson & AACAP, 2012, at 963.

discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality.”¹⁰⁸

115. The policy similarly includes a provision for resolving mental health issues: “Gender reassignment services are available in conjunction with mental health services focusing on exploration of gender identity, cross-sex treatment wishes, counseling during such treatment if any, and *treatment of associated mental health problems*.”¹⁰⁹ The document also includes minority stress issues and the need to deal with mental health aspects of minority status (*e.g.*, bullying).¹¹⁰

116. Rather than endorse social transition for prepubertal children, the AACAP indicates: “There is similarly no data at present from controlled studies to guide clinical decisions regarding the risks and benefits of sending gender discordant children to school in their desired gender. Such decisions must be made based on clinical judgment, bearing in mind the potential risks and benefits of doing so.”¹¹¹

5. American College of Obstetricians & Gynecologists (ACOG)

117. The American College of Obstetricians & Gynecologists (ACOG) published a “Committee Opinion” expressing recommendations in 2017. The statement indicates it was developed by the ACOG’s Committee on Adolescent Health Care, but does not indicate participation based on professional expertise or a systematic method of objectively assessing the existing research. It includes the disclaimer: “This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.”¹¹²

118. Prepubertal children do not typically have clinical contact with gynecologists, and the ACOG recommendations include that the client additionally

¹⁰⁸ Adelson & AACAP, 2012, at 968.

¹⁰⁹ Adelson & AACAP, 2012, at 970 (*italics added*).

¹¹⁰ Adelson & AACAP, 2012, at 969.

¹¹¹ Adelson & AACAP, 2012, at 969.

¹¹² ACOG, 2017, at 1.

have a primary health care provider.¹¹³

119. The ACOG statement cites the statements made by other medical associations—European Society for Pediatric Endocrinology (ESPE), PES, and the Endocrine Society—and by WPATH.¹¹⁴ It does not cite any professional association of *mental* health care providers, however. The ACOG recommendations repeat the previously mentioned eligibility/readiness criteria of having no mental illness that would hamper diagnosis and no medical contraindications to treatment. It notes: “*Before* any treatment is undertaken, the patient must display eligibility and readiness (Table 1), meaning that the adolescent has been evaluated by a mental health professional, has no contraindications to therapy, and displays an understanding of the risks involved.”¹¹⁵

120. The “Eligibility and Readiness Criteria” also include, “Diagnosis established for gender dysphoria, transgender, transsexualism.”¹¹⁶ This standard, requiring a formal diagnosis, forestalls affirmation-on-demand because self-declared self-identification is not sufficient for DSM diagnosis.

121. ACOG’s remaining recommendations pertain only to post-transition, medically oriented concerns. Pre-pubertal social transition is not mentioned in the document, and the outcomes studies of gender dysphoric (prepubescent) children are not cited.

6. American College of Physicians (ACP)

122. The American College of Physicians published a position paper broadly expressing support for the treatment of LGBT patients and their families, including nondiscrimination, antiharassment, and defining “family” by emotional rather than biological or legal relationships in visitation policies, and the inclusion of transgender

¹¹³ ACOG, 2017, at 1.

¹¹⁴ ACOG, 2017, at 1, 3.

¹¹⁵ ACOG, 2017, at 1, 3 (citing the Endocrine Society guidelines) (*italics added*).

¹¹⁶ ACOG, 2017, at 3 Table 1.

health care services in public and private health benefit plans.¹¹⁷

123. ACP did not provide guidelines or standards for child or adult gender transitions. The policy paper opposed attempting “reparative therapy;” however, the paper confabulated sexual orientation with gender identity in doing so. That is, on the one hand, ACP explicitly recognized that “[s]exual orientation and gender identity are inherently different.”¹¹⁸ It based this statement on the fact that “the American Psychological Association conducted a literature review of 83 studies on the efficacy of efforts to change *sexual orientation*.”¹¹⁹ The APA’s document, entitled “Report of the American Psychological Task Force on appropriate therapeutic responses to *sexual orientation*” does not include or reference research on gender identity.¹²⁰ Despite citing no research about transgenderism, the ACP nonetheless included in its statement: “Available research does not support the use of reparative therapy as an effective method in the treatment of LGBT persons.”¹²¹ That is, the inclusion of “T” with “LGB” is based on something other than the existing evidence.

124. There is another statement,¹²² which was funded by ACP and published in the Annals of Internal Medicine under its “*In the Clinic*” feature, noting that “‘In the Clinic’ does not necessarily represent official ACP clinical policy.”¹²³ The document discusses medical transition procedures for adults rather than for children, except to note that “[n]o medical intervention is indicated for prepubescent youth,”¹²⁴ that a “mental health provider can assist the child and family with identifying an appropriate time for a social transition,”¹²⁵ and that the “child should be assessed and managed for coexisting mood disorders during this period because risk for suicide is

¹¹⁷ Daniel & Butkus, 2015a, 2015b.

¹¹⁸ Daniel & Butkus, 2015b, at 2.

¹¹⁹ Daniel & Butkus, 2015b, at 8 (*italics added*).

¹²⁰ APA, 2009 (*italics added*).

¹²¹ Daniel & Butkus, 2015b, at 8 (*italics added*).

¹²² Safer & Tangpricha, 2019.

¹²³ Safer & Tangpricha, 2019, at ITC1.

¹²⁴ Safer & Tangpricha, 2019, at ITC9.

¹²⁵ Safer & Tangpricha, 2019, at ITC9.

higher than in their cisgender peers.”¹²⁶

7. American Academy of Pediatrics (AAP)

125. The policy of the American Academy of Pediatrics (AAP) is unique among the major medical associations in being the only one to endorse an affirmation-on-demand policy, including social transition before puberty without any watchful waiting period. Although changes in recommendations can obviously be appropriate in response to new research evidence, the AAP provided none. Rather, the research studies AAP cited in support of its policy simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing watchful waiting.¹²⁷ Moreover, of all the outcomes research published, the AAP policy cited *one*, and that without mentioning the outcome data it contained.¹²⁸

8. The ESPE-LWPES GnRH Analogs Consensus Conference Group

126. Included in the interest of completeness, there was also a collaborative report in 2009, between the European Society for Pediatric Endocrinology (ESPE) and the Lawson Wilkins Pediatric Endocrine Society (LWPES).¹²⁹ Thirty experts were convened, evenly divided between North American and European labs and evenly divided male/female, who comprehensively rated the research literature on gonadotropin-release hormone analogs in children.

127. The effort concluded that “[u]se of gonadotropin-releasing hormone analogs for conditions other than central precocious puberty requires additional investigation and cannot be suggested routinely.”¹³⁰ However, gender dysphoria was not explicitly mentioned as one of those other conditions.

¹²⁶ Safer & Tangpricha, 2019, at ITC9.

¹²⁷ Cantor, 2020.

¹²⁸ Cantor, 2020, at 1.

¹²⁹ Carel et al., 2009.

¹³⁰ Carel et al. 2009, at 752.

C. International Health Care Consensus

1. United Kingdom

128. The National Health Service (NHS) of the United Kingdom centralizes gender counselling and transitioning services in a single clinic, the Gender Identity Development Service (GIDS) of the Tavistock and Portman NHS Foundation Trust. Between 2008 and 2018, the number of referrals to the clinic had increased by a factor of 40, leading to a government inquiry into the causes¹³¹. The GIDS was repeatedly accused of over-diagnosing and permitting transition in cases despite indicators against patient transition, including by 35 members of the GIDS staff, who resigned by 2019¹³².

129. The NHS appointed Dr. Hilary Cass, former President of the Royal College of Paediatrics and Child Health, to conduct an independent review¹³³. That review included a systematic consolidation of all the research evidence, following established procedures for preventing the “cherry-picking” or selective citation favouring or down-playing any one conclusion¹³⁴. The review’s results were unambiguous: “The critical outcomes for decision making are the impact on gender dysphoria, mental health and quality of life. The quality of evidence for these outcomes was assessed as very low”¹³⁵, again using established procedures for assessing clinical research evidence (called GRADE). The review also assessed as “very low” the quality of evidence regarding “body image, psychosocial impact, engagement with health care services, impact on extent of an satisfaction with surgery and stopping treatment”¹³⁶. The report concluded that of the existing research, “The studies included in this evidence review are all small, uncontrolled observational studies, which are subject to bias and confounding....They suggest little change with GnRH analogues [puberty

¹³¹ Marsh, 2020; Rayner, 2018.

¹³² BBC, 2021; Donnelly, 2019.

¹³³ National Health Service, 2020, Sept. 22.

¹³⁴ National Institute for Health and Care Excellence, 2020.

¹³⁵ National Institute for Health and Care Excellence, 2020, p. 4.

¹³⁶ National Institute for Health and Care Excellence, 2020, p. 5.

blockers] from baseline to follow-up”¹³⁷.

2. Finland

130. In Finland, the assessments of mental health and preparedness of minors for transition services are centralized by law into two research clinics, Helsinki University Central Hospital and Tampere University Hospital. The eligibility of minors began in 2011. In 2019, Finnish researchers published an analysis of the outcomes of adolescents diagnosed with transsexualism and receiving cross-sex hormone treatment¹³⁸. That study showed that despite the purpose of medical transition to improve mental health: “Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development”¹³⁹. The patients who were functioning well after transition were those who were already functioning well before transition, and those who were functioning poorly, continued to function poorly after transition.

131. Consistent with the evidence, Finland’s health care service (Council for Choices in Health Care in Finland—COHERE) thus ended the surgical transition of minors, ruling in 2020 that “Surgical treatments are not part of the treatment methods for dysphoria caused by gender-related conflicts in minors” (COHERE, 2020). The review of the research concluded that “[N]o conclusions can be drawn on the stability of gender identity during the period of disorder caused by a psychiatric illness with symptoms that hamper development.” COHERE also greatly restricted access to puberty-blocking and other hormonal treatments, indicating they “may be considered if the need for it continues *after* the other psychiatric symptoms have

¹³⁷ National Institute for Health and Care Excellence, 2020, p. 13.

¹³⁸ Kaltiala et al., 2020.

¹³⁹ Kaltiala et al., 2020, p. 213.

ceased and adolescent development is progressing normally”¹⁴⁰. The council was explicit in noting the lack of research needed for decision-making, “There is also a need for more information on the *disadvantages* of procedures and on people who regret them”¹⁴¹.

3. Sweden

132. Sweden’s national health care policy regarding trans issues has developed quite similarly to that of the UK. Already in place 20 years ago, Swedish health care policy permitted otherwise eligible minors to receive puberty-blockers beginning at age 14 and cross-sex hormones at age 16.) At that time, only small numbers of minors sought medical transition services. An explosion of referrals ensued in 2013–2014. Sweden’s Board of Health and Welfare reported that, in 2018, the number of diagnoses of gender dysphoria was 15 times higher than 2008 among girls ages 13–17.

133. Sweden has long been very accepting with regard to sexual and gender diversity. In 2018, a law was proposed to lower the age of eligibility for ?surgical care from age 18 to 15, remove the requirement for parental consent, and lower legal change of gender to age 12. A series of cases of regret and suicide were reported in the Swedish media, leading to questions of mental health professionals failing to consider. In 2019, the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) therefore conducted its own comprehensive review of the research¹⁴². Like the UK, the Swedish investigation employed methods to ensure the encapsulation of the all the relevant evidence¹⁴³.

134. The SBU report came to the same conclusions as the UK commission. From 2022 forward, the Swedish National Board or Health and Welfare therefore

¹⁴⁰ Council for Choices in Health Care in Finland, 2020; italics added.

¹⁴¹ Council for Choices in Health Care in Finland, 2020; italics added.

¹⁴² Orange, 2020, Feb 22.

¹⁴³ Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2019.

“recommends restraint when it comes to hormone treatment...Based on the results that have emerged, the National Board of Health and Welfare’s overall conclusion is that the risks of anti-puberty and sex-confirming hormone treatment for those under 18 currently outweigh the possible benefits for the group as a whole”¹⁴⁴. Neither puberty blockers nor cross-sex hormones would be provided under age 16, and patients ages 16–18 would receive such treatments only within research settings (clinical trials monitored by the appropriate Swedish research ethics board).

4. France

135. In 2022, the Académie Nationale de Médecine of France issued a strongly worded statement, citing the Swedish ban on hormone treatments. “[A] great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects, and even serious complications, that some of the available therapies can cause...such as impact on growth, bone fragility, risk of sterility, emotional and intellectual consequences and, for girls, symptoms reminiscent of menopause”¹⁴⁵. For hormones, the Académie concluded “the greatest reserve is required in their use,” and for surgical treatments, “[T]heir irreversible nature must be emphasized.” The Académie did not outright ban medical interventions, but warned “the risk of over-diagnosis is real, as shown by the increasing number of transgender young adults wishing to “detransition”. Rather than medical interventions, it advised health care providers “to extend as much as possible the psychological support phase.” The Académie reviewed and emphasized the evidence indicating the very large and very sudden increase in youth requesting medical transition. It attributed the change, not to society now being more accepting of sexual diversity, but to social media, “underlining the addictive character of excessive consultation of social networks which is both

¹⁴⁴ Swedish National Board of Health and Welfare, 2022.

¹⁴⁵ Académie Nationale de Médecine, 2022, Feb. 25.

harmful to the psychological development of young people and responsible, for a very important part, of the growing sense of gender incongruence.”

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APPENDICES

Appendix 1

Curriculum Vita

Appendix 2

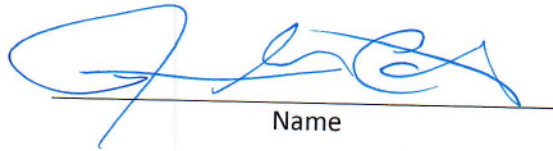
Peer-reviewed article:

Cantor, J. M. (2020). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of Sex & Marital Therapy*, 46, 307–313. doi: 10.1080/0092623X.2019.1698481

Appendix 3

The Outcomes Studies of Childhood-Onset Gender Dysphoria

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed on 30 April, 2022.



Name

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EDUCATION

Postdoctoral Fellowship

Centre for Addiction and Mental Health • Toronto, Canada

Jan., 2000–May, 2004

Doctor of Philosophy

Psychology • McGill University • Montréal, Canada

Sep., 1993–Jun., 2000

Master of Arts

Psychology • Boston University • Boston, MA

Sep., 1990–Jan., 1992

Bachelor of Science

Interdisciplinary Science • Rensselaer Polytechnic Institute • Troy, NY
Concentrations: Computer science, mathematics, physics

Sep. 1984–Aug., 1988

EMPLOYMENT HISTORY

Director

Toronto Sexuality Centre • Toronto, Canada

Feb., 2017–Present

Senior Scientist (Inaugural Member)

Campbell Family Mental Health Research Institute
Centre for Addiction and Mental Health • Toronto, Canada

Aug., 2012–May, 2018

Senior Scientist

Complex Mental Illness Program
Centre for Addiction and Mental Health • Toronto, Canada

Jan., 2012–May, 2018

Head of Research

Sexual Behaviours Clinic
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Nov., 2010–Apr. 2014

Research Section Head

Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

Dec., 2009–Sep. 2012

Psychologist

Law & Mental Health Program
Centre for Addiction and Mental Health • Toronto, Canada

May, 2004–Dec., 2011

Clinical Psychology Intern Sep., 1998–Aug., 1999
Centre for Addiction and Mental Health • Toronto, Canada

Teaching Assistant Sep., 1993–May, 1998
Department of Psychology
McGill University • Montréal, Canada

Pre-Doctoral Practicum Sep., 1993–Jun., 1997
Sex and Couples Therapy Unit
Royal Victoria Hospital • Montréal, Canada

Pre-Doctoral Practicum May, 1994–Dec., 1994
Department of Psychiatry
Queen Elizabeth Hospital • Montréal, Canada

ACADEMIC APPOINTMENTS

Associate Professor Jul., 2010–May, 2019
Department of Psychiatry
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Graduate Program in Psychology
York University • Toronto, Canada

Associate Faculty (Hon) Oct., 2017–Dec., 2017
School of Behavioural, Cognitive & Social Science
University of New England • Armidale, Australia

Assistant Professor Jun., 2005–Jun., 2010
Department of Psychiatry
University of Toronto Faculty of Medicine • Toronto, Canada

Adjunct Faculty Sep., 2004–Jun., 2010
Clinical Psychology Residency Program
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PUBLICATIONS

1. Cantor, J. M. (2020). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of Sex & Marital Therapy*, 46, 307–313. doi: 10.1080/0092623X.2019.1698481
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6. Cantor, J. M., & Fedoroff, J. P. (2018). Can pedophiles change? Response to opening arguments and conclusions. *Current Sexual Health Reports*, 10, 213–220. doi: 10.1007/s11930-018-0167-0z
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10. Cantor, J. M. (2017). Sexual deviance or social deviance: What MRI research reveals about pedophilia. *ATSA Forum*, 29(2). Association for the Treatment of Sexual Abusers. Beaverton, OR. <http://newsmanager.commpartners.com/atsa/issues/2017-03-15/2.html>
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PUBLICATIONS

LETTERS AND COMMENTARIES

1. Cantor, J. M. (2015). Research methods, statistical analysis, and the phallometric test for hebephilia: Response to Fedoroff [Editorial Commentary]. *Journal of Sexual Medicine*, 12, 2499–2500. doi: 10.1111/jsm.13040
2. Cantor, J. M. (2015). In his own words: Response to Moser [Editorial Commentary]. *Journal of Sexual Medicine*, 12, 2502–2503. doi: 10.1111/jsm.13075
3. Cantor, J. M. (2015). Purported changes in pedophilia as statistical artefacts: Comment on Müller et al. (2014). *Archives of Sexual Behavior*, 44, 253–254. doi: 10.1007/s10508-014-0343-x
4. McPhail, I. V., & Cantor, J. M. (2015). Pedophilia, height, and the magnitude of the association: A research note. *Deviant Behavior*, 36, 288–292. doi: 10.1080/01639625.2014.935644
5. Soh, D. W., & Cantor, J. M. (2015). A peek inside a furry convention [Letter to the Editor]. *Archives of Sexual Behavior*, 44, 1–2. doi: 10.1007/s10508-014-0423-y
6. Cantor, J. M. (2012). Reply to Italiano's (2012) comment on Cantor (2011) [Letter to the Editor]. *Archives of Sexual Behavior*, 41, 1081–1082. doi: 10.1007/s10508-012-0011-y
7. Cantor, J. M. (2012). The errors of Karen Franklin's *Pretextuality* [Commentary]. *International Journal of Forensic Mental Health*, 11, 59–62. doi: 10.1080/14999013.2012.672945
8. Cantor, J. M., & Blanchard, R. (2012). White matter volumes in pedophiles, hebephiles, and teleiophiles [Letter to the Editor]. *Archives of Sexual Behavior*, 41, 749–752. doi: 10.1007/s10508-012-9954-2
9. Cantor, J. M. (2011). New MRI studies support the Blanchard typology of male-to-female transsexualism [Letter to the Editor]. *Archives of Sexual Behavior*, 40, 863–864. doi: 10.1007/s10508-011-9805-6
10. Zucker, K. J., Bradley, S. J., Own-Anderson, A., Kibblewhite, S. J., & Cantor, J. M. (2008). Is gender identity disorder in adolescents coming out of the closet? *Journal of Sex and Marital Therapy*, 34, 287–290.
11. Cantor, J. M. (2003, Summer). Review of the book *The Man Who Would Be Queen* by J. Michael Bailey. *Newsletter of Division 44 of the American Psychological Association*, 19(2), 6.
12. Cantor, J. M. (2003, Spring). What are the hot topics in LGBT research in psychology? *Newsletter of Division 44 of the American Psychological Association*, 19(1), 21–24.
13. Cantor, J. M. (2002, Fall). Male homosexuality, science, and pedophilia. *Newsletter of Division 44 of the American Psychological Association*, 18(3), 5–8.
14. Cantor, J. M. (2000). Review of the book *Sexual Addiction: An Integrated Approach*. *Journal of Sex and Marital Therapy*, 26, 107–109.

EDITORIALS

1. Cantor, J. M. (2012). Editorial. *Sexual Abuse: A Journal of Research and Treatment*, 24.

2. Cantor, J. M. (2011). Editorial note. *Sexual Abuse: A Journal of Research and Treatment*, 23, 414.
3. Barbaree, H. E., & Cantor, J. M. (2010). Performance indicators for *Sexual Abuse: A Journal of Research and Treatment* (SAJRT) [Editorial]. *Sexual Abuse: A Journal of Research and Treatment*, 22, 371–373.
4. Barbaree, H. E., & Cantor, J. M. (2009). *Sexual Abuse: A Journal of Research and Treatment* performance indicators for 2007 [Editorial]. *Sexual Abuse: A Journal of Research and Treatment*, 21, 3–5.
5. Zucker, K. J., & Cantor, J. M. (2009). Cruising: Impact factor data [Editorial]. *Archives of Sexual Research*, 38, 878–882.
6. Barbaree, H. E., & Cantor, J. M. (2008). Performance indicators for *Sexual Abuse: A Journal of Research and Treatment* [Editorial]. *Sexual Abuse: A Journal of Research and Treatment*, 20, 3–4.
7. Zucker, K. J., & Cantor, J. M. (2008). The *Archives* in the era of online first ahead of print [Editorial]. *Archives of Sexual Behavior*, 37, 512–516.
8. Zucker, K. J., & Cantor, J. M. (2006). The impact factor: The *Archives* breaks from the pack [Editorial]. *Archives of Sexual Behavior*, 35, 7–9.
9. Zucker, K. J., & Cantor, J. M. (2005). The impact factor: “Goin’ up” [Editorial]. *Archives of Sexual Behavior*, 34, 7–9.
10. Zucker, K., & Cantor, J. M. (2003). The numbers game: The impact factor and all that jazz [Editorial]. *Archives of Sexual Behavior*, 32, 3–5.

FUNDING HISTORY

Principal Investigators: Doug VanderLaan, Meng-Chuan Lai
Co-Investigators: James M. Cantor, Megha Mallar Chakravarty, Nancy Lobaugh, M. Palmert, M. Skorska
Title: *Brain function and connectomics following sex hormone treatment in adolescents experience gender dysphoria*
Agency: Canadian Institutes of Health Research (CIHR), Behavioural Sciences-B-2
Funds: \$650,250 / 5 years (July, 2018)

Principal Investigator: Michael C. Seto
Co-Investigators: Martin Lalumière, James M. Cantor
Title: *Are connectivity differences unique to pedophilia?*
Agency: University Medical Research Fund, Royal Ottawa Hospital
Funds: \$50,000 / 1 year (January, 2018)

Principal Investigator: Lori Brotto
Co-Investigators: Anthony Bogaert, James M. Cantor, Gerulf Rieger
Title: *Investigations into the neural underpinnings and biological correlates of asexuality*
Agency: Natural Sciences and Engineering Research Council (NSERC), Discovery Grants Program
Funds: \$195,000 / 5 years (April, 2017)

Principal Investigator: Doug VanderLaan
Co-Investigators: Jerald Bain, James M. Cantor, Megha Mallar Chakravarty, Sofia Chavez, Nancy Lobaugh, and Kenneth J. Zucker
Title: *Effects of sex hormone treatment on brain development: A magnetic resonance imaging study of adolescents with gender dysphoria*
Agency: Canadian Institutes of Health Research (CIHR), Transitional Open Grant Program
Funds: \$952,955 / 5 years (September, 2015)

Principal Investigator: James M. Cantor
Co-Investigators: Howard E. Barbaree, Ray Blanchard, Robert Dickey, Todd A. Girard, Phillip E. Klassen, and David J. Mikulis
Title: *Neuroanatomic features specific to pedophilia*
Agency: Canadian Institutes of Health Research (CIHR)
Funds: \$1,071,920 / 5 years (October, 2008)

Principal Investigator: James M. Cantor
Title: *A preliminary study of fMRI as a diagnostic test of pedophilia*
Agency: Dean of Medicine New Faculty Grant Competition, Univ. of Toronto
Funds: \$10,000 (July, 2008)

Principal Investigator: James M. Cantor
Co-Investigator: Ray Blanchard
Title: *Morphological and neuropsychological correlates of pedophilia*
Agency: Canadian Institutes of Health Research (CIHR)
Funds: \$196,902 / 3 years (April, 2006)

KEYNOTE AND INVITED ADDRESSES

1. Cantor, J. M. (2021, September 28). *No topic too tough for this expert panel: A year in review*. Plenary Session for the 40th Annual Research and Treatment Conference, Association for the Treatment of Sexual Abusers.
2. Cantor, J. M. (2019, May 1). *Introduction and Q&A for 'I, Pedophile.'* StopSO 2nd Annual Conference, London, UK.
3. Cantor, J. M. (2018, August 29). *Neurobiology of pedophilia or paraphilia? Towards a 'Grand Unified Theory' of sexual interests*. Keynote address to the International Association for the Treatment of Sexual Offenders, Vilnius, Lithuania.
4. Cantor, J. M. (2018, August 29). *Pedophilia and the brain: Three questions asked and answered*. Preconference training presented to the International Association for the Treatment of Sexual Offenders, Vilnius, Lithuania.
5. Cantor, J. M. (2018, April 13). *The responses to I, Pedophile from We, the people*. Keynote address to the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, Minnesota.
6. Cantor, J. M. (2018, April 11). *Studying atypical sexualities: From vanilla to I, Pedophile*. Full day workshop at the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, Minnesota.
7. Cantor, J. M. (2018, January 20). *How much sex is enough for a happy life?* Invited lecture to the University of Toronto Division of Urology Men's Health Summit, Toronto, Canada.
8. Cantor, J. M. (2017, November 2). *Pedophilia as a phenomenon of the brain: Update of evidence and the public response*. Invited presentation to the 7th annual SBC education event, Centre for Addiction and Mental Health, Toronto, Canada.
9. Cantor, J. M. (2017, June 9). *Pedophilia being in the brain: The evidence and the public's reaction*. Invited presentation to *SEXposium at the ROM: The science of love and sex*, Toronto, Canada.
10. Cantor, J. M., & Campea, M. (2017, April 20). *"I, Pedophile" showing and discussion*. Invited presentation to the 42nd annual meeting of the Society for Sex Therapy and Research, Montréal, Canada.
11. Cantor, J. M. (2017, March 1). *Functional and structural neuroimaging of pedophilia: Consistencies across methods and modalities*. Invited lecture to the Brain Imaging Centre, Royal Ottawa Hospital, Ottawa, Canada.
12. Cantor, J. M. (2017, January 26). *Pedophilia being in the brain: The evidence and the public reaction*. Inaugural keynote address to the University of Toronto Sexuality Interest Network, Toronto, Ontario, Canada.
13. Cantor, J. M. (2016, October 14). *Discussion of CBC's "I, Pedophile."* Office of the Children's Lawyer Educational Session, Toronto, Ontario, Canada.
14. Cantor, J. M. (2016, September 15). *Evaluating the risk to reoffend: What we know and what we don't*. Invited lecture to the Association of Ontario Judges, Ontario Court of Justice Annual Family Law Program, Blue Mountains, Ontario, Canada. [Private link only: <https://vimeo.com/239131108/3387c80652>]
15. Cantor, J. M. (2016, April 8). *Pedophilia and the brain: Conclusions from the second generation of research*. Invited lecture at the 10th annual Risk and Recovery Forensic Conference, Hamilton, Ontario.

16. Cantor, J. M. (2016, April 7). *Hypersexuality without the hyperbole*. Keynote address to the 10th annual Risk and Recovery Forensic Conference, Hamilton, Ontario.
17. Cantor, J. M. (2015, November). *No one asks to be sexually attracted to children: Living in Daniel's World*. Grand Rounds, Centre for Addiction and Mental Health. Toronto, Canada.
18. Cantor, J. M. (2015, August). *Hypersexuality: Getting past whether "it" is or "it" isn't*. Invited address at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
19. Cantor, J. M. (2015, July). *A unified theory of typical and atypical sexual interest in men: Paraphilia, hypersexuality, asexuality, and vanilla as outcomes of a single, dual opponent process*. Invited presentation to the 2015 Puzzles of Sexual Orientation conference, Lethbridge, AL, Canada.
20. Cantor, J. M. (2015, June). *Hypersexuality*. Keynote Address to the Ontario Problem Gambling Provincial Forum. Toronto, Canada.
21. Cantor, J. M. (2015, May). *Assessment of pedophilia: Past, present, future*. Keynote Address to the International Symposium on Neural Mechanisms Underlying Pedophilia and Child Sexual Abuse (NeMUP). Berlin, Germany.
22. Cantor, J. M. (2015, March). *Prevention of sexual abuse by tackling the biggest stigma of them all: Making sex therapy available to pedophiles*. Keynote address to the 40th annual meeting of the Society for Sex Therapy and Research, Boston, MA.
23. Cantor, J. M. (2015, March). *Pedophilia: Predisposition or perversion?* Panel discussion at Columbia University School of Journalism. New York, NY.
24. Cantor, J. M. (2015, February). *Hypersexuality*. Research Day Grand Rounds presentation to Ontario Shores Centre for Mental Health Sciences, Whitby, Ontario, Canada.
25. Cantor, J. M. (2015, January). *Brain research and pedophilia: What it means for assessment, research, and policy*. Keynote address to the inaugural meeting of the Netherlands Association for the Treatment of Sexual Abusers, Utrecht, Netherlands.
26. Cantor, J. M. (2014, December). *Understanding pedophilia and the brain: Implications for safety and society*. Keynote address for The Jewish Community Confronts Violence and Abuse: Crisis Centre for Religious Women, Jerusalem, Israel.
27. Cantor, J. M. (2014, October). *Understanding pedophilia & the brain*. Invited full-day workshop for the Sex Offender Assessment Board of Pennsylvania, Harrisburg, PA.
28. Cantor, J. M. (2014, September). *Understanding neuroimaging of pedophilia: Current status and implications*. Invited lecture presented to the Mental Health and Addiction Rounds, St. Joseph's Healthcare, Hamilton, Ontario, Canada.
29. Cantor, J. M. (2014, June). *An evening with Dr. James Cantor*. Invited lecture presented to the Ontario Medical Association, District 11 Doctors' Lounge Program, Toronto, Ontario, Canada.
30. Cantor, J. M. (2014, April). *Pedophilia and the brain*. Invited lecture presented to the University of Toronto Medical Students lunchtime lecture. Toronto, Ontario, Canada.
31. Cantor, J. M. (2014, February). *Pedophilia and the brain: Recap and update*. Workshop presented at the 2014 annual meeting of the Washington State Association for the Treatment of Sexual Abusers, Cle Elum, WA.
32. Cantor, J. M., Lafaille, S., Hannah, J., Kucyi, A., Soh, D., Girard, T. A., & Mikulis, D. M. (2014, February). *Functional connectivity in pedophilia*. Neuropsychiatry Rounds, Toronto Western Hospital, Toronto, Ontario, Canada.

33. Cantor, J. M. (2013, November). *Understanding pedophilia and the brain: The basics, the current status, and their implications*. Invited lecture to the Forensic Psychology Research Centre, Carleton University, Ottawa, Canada.
34. Cantor, J. M. (2013, November). *Mistaking puberty, mistaking hebephilia*. Keynote address presented to the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
35. Cantor, J. M. (2013, October). *Understanding pedophilia and the brain: A recap and update*. Invited workshop presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
36. Cantor, J. M. (2013, October). *Compulsive-hyper-sex-addiction: I don't care what we all it, what can we do?* Invited address presented to the Board of Examiners of Sex Therapists and Counselors of Ontario, Toronto, Ontario, Canada.
37. Cantor, J. M. (2013, September). *Neuroimaging of pedophilia: Current status and implications*. McGill University Health Centre, Department of Psychiatry Grand Rounds presentation, Montréal, Québec, Canada.
38. Cantor, J. M. (2013, April). *Understanding pedophilia and the brain*. Invited workshop presented at the 2013 meeting of the Minnesota Association for the Treatment of Sexual Abusers, Minneapolis, MN.
39. Cantor, J. M. (2013, April). *The neurobiology of pedophilia and its implications for assessment, treatment, and public policy*. Invited lecture at the 38th annual meeting of the Society for Sex Therapy and Research, Baltimore, MD.
40. Cantor, J. M. (2013, April). *Sex offenders: Relating research to policy*. Invited roundtable presentation at the annual meeting of the Academy of Criminal Justice Sciences, Dallas, TX.
41. Cantor, J. M. (2013, March). *Pedophilia and brain research: From the basics to the state-of-the-art*. Invited workshop presented to the annual meeting of the Forensic Mental Health Association of California, Monterey, CA.
42. Cantor, J. M. (2013, January). *Pedophilia and child molestation*. Invited lecture presented to the Canadian Border Services Agency, Toronto, Ontario, Canada.
43. Cantor, J. M. (2012, November). *Understanding pedophilia and sexual offenders against children: Neuroimaging and its implications for public safety*. Invited guest lecture to University of New Mexico School of Medicine Health Sciences Center, Albuquerque, NM.
44. Cantor, J. M. (2012, November). *Pedophilia and brain research*. Invited guest lecture to the annual meeting of the Circles of Support and Accountability, Toronto, Ontario, Canada.
45. Cantor, J. M. (2012, January). *Current findings on pedophilia brain research*. Invited workshop at the San Diego International Conference on Child and Family Maltreatment, San Diego, CA.
46. Cantor, J. M. (2012, January). *Pedophilia and the risk to re-offend*. Invited lecture to the Ontario Court of Justice Judicial Development Institute, Toronto, Ontario, Canada.
47. Cantor, J. M. (2011, November). *Pedophilia and the brain: What it means for assessment, treatment, and policy*. Plenary Lecture presented at the Association for the Treatment of Sexual Abusers, Toronto, Ontario, Canada.
48. Cantor, J. M. (2011, July). *Towards understanding contradictory findings in the neuroimaging of pedophilic men*. Keynote address to 7th annual conference on Research in Forensic Psychiatry, Regensburg, Germany.

49. Cantor, J. M. (2011, March). *Understanding sexual offending and the brain: Brain basics to the state of the art*. Workshop presented at the winter conference of the Oregon Association for the Treatment of Sexual Abusers, Oregon City, OR.
50. Cantor, J. M. (2010, October). *Manuscript publishing for students*. Workshop presented at the 29th annual meeting of the Association for the Treatment of Sexual Abusers, Phoenix, AZ.
51. Cantor, J. M. (2010, August). *Is sexual orientation a paraphilia?* Invited lecture at the International Behavioral Development Symposium, Lethbridge, Alberta, Canada.
52. Cantor, J. M. (2010, March). *Understanding sexual offending and the brain: From the basics to the state of the art*. Workshop presented at the annual meeting of the Washington State Association for the Treatment of Sexual Abusers, Blaine, WA.
53. Cantor, J. M. (2009, January). *Brain structure and function of pedophilia men*. Neuropsychiatry Rounds, Toronto Western Hospital, Toronto, Ontario.
54. Cantor, J. M. (2008, April). *Is pedophilia caused by brain dysfunction?* Invited address to the University-wide Science Day Lecture Series, SUNY Oswego, Oswego, NY.
55. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2006, September). *MRIs of pedophilic men*. Invited presentation at the 25th annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
56. Cantor, J. M., Blanchard, R., & Christensen, B. K. (2003, March). *Findings in and implications of neuropsychology and epidemiology of pedophilia*. Invited lecture at the 28th annual meeting of the Society for Sex Therapy and Research, Miami.
57. Cantor, J. M., Christensen, B. K., Klassen, P. E., Dickey, R., & Blanchard, R. (2001, July). *Neuropsychological functioning in pedophiles*. Invited lecture presented at the 27th annual meeting of the International Academy of Sex Research, Bromont, Canada.
58. Cantor, J. M., Blanchard, R., Christensen, B., Klassen, P., & Dickey, R. (2001, February). *First glance at IQ, memory functioning and handedness in sex offenders*. Lecture presented at the Forensic Lecture Series, Centre for Addiction and Mental Health, Toronto, Ontario, Canada.
59. Cantor, J. M. (1999, November). *Reversal of SSRI-induced male sexual dysfunction: Suggestions from an animal model*. Grand Rounds presentation at the Allan Memorial Institute, Royal Victoria Hospital, Montréal, Canada.

PAPER PRESENTATIONS AND SYMPOSIA

1. Cantor, J. M. (2020, April). "I'd rather have a trans kid than a dead kid": Critical assessment of reported rates of suicidality in trans kids. *Paper presented at the annual meeting of the Society for the Sex Therapy and Research*. Online in lieu of in person meeting.
2. Stephens, S., Lalumière, M., Seto, M. C., & Cantor, J. M. (2017, October). *The relationship between sexual responsiveness and sexual exclusivity in phallometric profiles*. Paper presented at the annual meeting of the Canadian Sex Research Forum, Fredericton, New Brunswick, Canada.
3. Stephens, S., Cantor, J. M., & Seto, M. C. (2017, March). *Can the SSPI-2 detect hebephilic sexual interest?* Paper presented at the annual meeting of the American-Psychology Law Society Annual Meeting, Seattle, WA.
4. Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2015, October). *Victim choice polymorphism and recidivism*. Symposium Presentation. Paper presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
5. McPhail, I. V., Hermann, C. A., Fernane, S. Fernandez, Y., Cantor, J. M., & Nunes, K. L. (2014, October). *Sexual deviance in sexual offenders against children: A meta-analytic review of phallometric research*. Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
6. Stephens, S., Seto, M. C., Cantor, J. M., & Goodwill, A. M. (2014, October). *Is hebephilic sexual interest a criminogenic need?: A large scale recidivism study*. Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
7. Stephens, S., Seto, M. C., Cantor, J. M., & Lalumière, M. (2014, October). *Development and validation of the Revised Screening Scale for Pedophilic Interests (SSPI-2)*. Paper presented at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
8. Cantor, J. M., Lafaille, S., Hannah, J., Kucyi, A., Soh, D., Girard, T. A., & Mikulis, D. M. (2014, September). *Pedophilia and the brain: White matter differences detected with DTI*. Paper presented at the 13th annual meeting of the International Association for the Treatment of Sexual Abusers, Porto, Portugal.
9. Stephens, S., Seto, M., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2014, March). *The role of hebephilic sexual interests in sexual victim choice*. Paper presented at the annual meeting of the American Psychology and Law Society, New Orleans, LA.
10. McPhail, I. V., Fernane, S. A., Hermann, C. A., Fernandez, Y. M., Nunes, K. L., & Cantor, J. M. (2013, November). *Sexual deviance and sexual recidivism in sexual offenders against children: A meta-analysis*. Paper presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago, IL.
11. Cantor, J. M. (2013, September). *Pedophilia and the brain: Current MRI research and its implications*. Paper presented at the 21st annual World Congress for Sexual Health, Porto Alegre, Brazil. [Featured among Best Abstracts, top 10 of 500.]
12. Cantor, J. M. (Chair). (2012, March). *Innovations in sex research*. Symposium conducted at the 37th annual meeting of the Society for Sex Therapy and Research, Chicago.
13. Cantor, J. M., & Blanchard, R. (2011, August). fMRI versus phallometry in the diagnosis of pedophilia and hebephilia. In J. M. Cantor (Chair), *Neuroimaging of men's object*

- preferences*. Symposium presented at the 37th annual meeting of the International Academy of Sex Research, Los Angeles, USA.
14. Cantor, J. M. (Chair). (2011, August). *Neuroimaging of men's object preferences*. Symposium conducted at the 37th annual meeting of the International Academy of Sex Research, Los Angeles.
 15. Cantor, J. M. (2010, October). A meta-analysis of neuroimaging studies of male sexual arousal. In S. Stolerú (Chair), *Brain processing of sexual stimuli in pedophilia: An application of functional neuroimaging*. Symposium presented at the 29th annual meeting of the Association for the Treatment of Sexual Abusers, Phoenix, AZ.
 16. Chivers, M. L., Seto, M. C., Cantor, J. C., Grimbos, T., & Roy, C. (April, 2010). *Psychophysiological assessment of sexual activity preferences in women*. Paper presented at the 35th annual meeting of the Society for Sex Therapy and Research, Boston, USA.
 17. Cantor, J. M., Girard, T. A., & Lovett-Barron, M. (2008, November). *The brain regions that respond to erotica: Sexual neuroscience for dummies*. Paper presented at the 51st annual meeting of the Society for the Scientific Study of Sexuality, San Juan, Puerto Rico.
 18. Barbaree, H., Langton, C., Blanchard, R., & Cantor, J. M. (2007, October). *The role of age-at-release in the evaluation of recidivism risk of sexual offenders*. Paper presented at the 26th annual meeting of the Association for the Treatment of Sexual Abusers, San Diego.
 19. Cantor, J. M., Kabani, N., Christensen, B. K., Zipursky, R. B., Barbaree, H. E., Dickey, R., Klassen, P. E., Mikulis, D. J., Kuban, M. E., Blak, T., Richards, B. A., Hanratty, M. K., & Blanchard, R. (2006, July). *Pedophilia and brain morphology*. Abstract and paper presented at the 32nd annual meeting of the International Academy of Sex Research, Amsterdam, Netherlands.
 20. Seto, M. C., Cantor, J. M., & Blanchard, R. (2006, March). *Child pornography offending is a diagnostic indicator of pedophilia*. Paper presented at the 2006 annual meeting of the American Psychology-Law Society Conference, St. Petersburg, Florida.
 21. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove, S. M., & Ellis, L. (2005, August). *Interaction of fraternal birth order and handedness in the development of male homosexuality*. Abstract and paper presented at the International Behavioral Development Symposium, Minot, North Dakota.
 22. Cantor, J. M., & Blanchard, R. (2005, July). *Quantitative reanalysis of aggregate data on IQ in sexual offenders*. Abstract and poster presented at the 31st annual meeting of the International Academy of Sex Research, Ottawa, Canada.
 23. Cantor, J. M. (2003, August). *Sex reassignment on demand: The clinician's dilemma*. Paper presented at the 111th annual meeting of the American Psychological Association, Toronto, Canada.
 24. Cantor, J. M. (2003, June). *Meta-analysis of VIQ-PIQ differences in male sex offenders*. Paper presented at the Harvey Stancer Research Day, Toronto, Ontario, Canada.
 25. Cantor, J. M. (2002, August). *Gender role in autogynephilic transsexuals: The more things change...* Paper presented at the 110th annual meeting of the American Psychological Association, Chicago.

26. Cantor, J. M., Christensen, B. K., Klassen, P. E., Dickey, R., & Blanchard, R. (2001, June). *IQ, memory functioning, and handedness in male sex offenders*. Paper presented at the Harvey Stancer Research Day, Toronto, Ontario, Canada.
27. Cantor, J. M. (1998, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 106th annual meeting of the American Psychological Association.
28. Cantor, J. M. (1997, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 105th annual meeting of the American Psychological Association.
29. Cantor, J. M. (1997, August). *Convention orientation for lesbian, gay, and bisexual students*. Paper presented at the 105th annual meeting of the American Psychological Association.
30. Cantor, J. M. (1996, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 104th annual meeting of the American Psychological Association.
31. Cantor, J. M. (1996, August). *Symposium: Question of inclusion: Lesbian and gay psychologists and accreditation*. Paper presented at the 104th annual meeting of the American Psychological Association, Toronto.
32. Cantor, J. M. (1996, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 104th annual meeting of the American Psychological Association.
33. Cantor, J. M. (1995, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 103rd annual meeting of the American Psychological Association.
34. Cantor, J. M. (1995, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 103rd annual meeting of the American Psychological Association.
35. Cantor, J. M. (1994, August). *Discussion hour for lesbian, gay, and bisexual students*. Presented at the 102nd annual meeting of the American Psychological Association.
36. Cantor, J. M. (1994, August). *Convention orientation for lesbian, gay, and bisexual students*. Papers presented at the 102nd annual meeting of the American Psychological Association.
37. Cantor, J. M., & Pilkington, N. W. (1992, August). *Homophobia in psychology programs: A survey of graduate students*. Paper presented at the Centennial Convention of the American Psychological Association, Washington, DC. (ERIC Document Reproduction Service No. ED 351 618)
38. Cantor, J. M. (1991, August). *Being gay and being a graduate student: Double the memberships, four times the problems*. Paper presented at the 99th annual meeting of the American Psychological Association, San Francisco.

POSTER PRESENTATIONS

1. Klein, L., Stephens, S., Goodwill, A. M., Cantor, J. M., & Seto, M. C. (2015, October). *The psychological propensities of risk in undetected sexual offenders*. Poster presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
2. Pullman, L. E., Stephens, S., Seto, M. C., Goodwill, A. M., & Cantor, J. M. (2015, October). *Why are incest offenders less likely to recidivate?* Poster presented at the 34th annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, Canada.
3. Seto, M. C., Stephens, S. M., Cantor, J. M., Lalumiere, M. L., Sandler, J. C., & Freeman, N. A. (2015, August). *The development and validation of the Revised Screening Scale for Pedophilic Interests (SSPI-2)*. Poster presentation at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
4. Soh, D. W., & Cantor, J. M. (2015, August). *A peek inside a furry convention*. Poster presentation at the 41st annual meeting of the International Academy of Sex Research. Toronto, Canada.
5. VanderLaan, D. P., Lobaugh, N. J., Chakravarty, M. M., Patel, R., Chavez, S. Stojanovski, S. O., Takagi, A., Hughes, S. K., Wasserman, L., Bain, J., Cantor, J. M., & Zucker, K. J. (2015, August). *The neurohormonal hypothesis of gender dysphoria: Preliminary evidence of cortical surface area differences in adolescent natal females*. Poster presentation at the 31st annual meeting of the International Academy of Sex Research. Toronto, Canada.
6. Cantor, J. M., Lafaille, S. J., Moayedi, M., Mikulis, D. M., & Girard, T. A. (2015, June). *Diffusion tensor imaging (DTI) of the brain in pedohebephilic men: Preliminary analyses*. Harvey Stancer Research Day, Toronto, Ontario Canada.
7. Newman, J. E., Stephens, S., Seto, M. C., & Cantor, J. M. (2014, October). *The validity of the Static-99 in sexual offenders with low intellectual abilities*. Poster presentation at the 33rd annual meeting of the Association for the Treatment of Sexual Abusers, San Diego, CA.
8. Lykins, A. D., Walton, M. T., & Cantor, J. M. (2014, June). *An online assessment of personality, psychological, and sexuality trait variables associated with self-reported hypersexual behavior*. Poster presentation at the 30th annual meeting of the International Academy of Sex Research, Dubrovnik, Croatia.
9. Stephens, S., Seto, M. C., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2013, November). *The utility of phallometry in the assessment of hebephilia*. Poster presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
10. Stephens, S., Seto, M. C., Cantor, J. M., Goodwill, A. M., & Kuban, M. (2013, October). *The role of hebephilic sexual interests in sexual victim choice*. Poster presented at the 32nd annual meeting of the Association for the Treatment of Sexual Abusers, Chicago.
11. Fazio, R. L., & Cantor, J. M. (2013, October). *Analysis of the Fazio Laterality Inventory (FLI) in a population with established atypical handedness*. Poster presented at the 33rd annual meeting of the National Academy of Neuropsychology, San Diego.
12. Lafaille, S., Hannah, J., Soh, D., Kucyi, A., Girard, T. A., Mikulis, D. M., & Cantor, J. M. (2013, August). *Investigating resting state networks in pedohebephiles*. Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.

13. McPhail, I. V., Lykins, A. D., Robinson, J. J., LeBlanc, S., & Cantor, J. M. (2013, August). *Effects of prescription medication on volumetric phallometry output*. Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.
14. Murray, M. E., Dyshniku, F., Fazio, R. L., & Cantor, J. M. (2013, August). *Minor physical anomalies as a window into the prenatal origins of pedophilia*. Poster presented at the 29th annual meeting of the International Academy of Sex Research, Chicago.
15. Sutton, K. S., Stephens, S., Dyshniku, F., Tulloch, T., & Cantor, J. M. (2013, August). *Pilot group treatment for "procrasturbation."* Poster presented at 39th annual meeting of the International Academy of Sex Research, Chicago.
16. Sutton, K. S., Pytyck, J., Stratton, N., Sylva, D., Kolla, N., & Cantor, J. M. (2013, August). *Client characteristics by type of hypersexuality referral: A quantitative chart review*. Poster presented at the 39th annual meeting of the International Academy of Sex Research, Chicago.
17. Fazio, R. L., & Cantor, J. M. (2013, June). *A replication and extension of the psychometric properties of the Digit Vigilance Test*. Poster presented at the 11th annual meeting of the American Academy of Clinical Neuropsychology, Chicago.
18. Lafaille, S., Moayed, M., Mikulis, D. M., Girard, T. A., Kuban, M., Blak, T., & Cantor, J. M. (2012, July). *Diffusion Tensor Imaging (DTI) of the brain in pedohebephilic men: Preliminary analyses*. Poster presented at the 38th annual meeting of the International Academy of Sex Research, Lisbon, Portugal.
19. Lykins, A. D., Cantor, J. M., Kuban, M. E., Blak, T., Dickey, R., Klassen, P. E., & Blanchard, R. (2010, July). *Sexual arousal to female children in gynephilic men*. Poster presented at the 38th annual meeting of the International Academy of Sex Research, Prague, Czech Republic.
20. Cantor, J. M., Girard, T. A., Lovett-Barron, M., & Blak, T. (2008, July). *Brain regions responding to visual sexual stimuli: Meta-analysis of PET and fMRI studies*. Abstract and poster presented at the 34th annual meeting of the International Academy of Sex Research, Leuven, Belgium.
21. Lykins, A. D., Blanchard, R., Cantor, J. M., Blak, T., & Kuban, M. E. (2008, July). *Diagnosing sexual attraction to children: Considerations for DSM-V*. Poster presented at the 34th annual meeting of the International Academy of Sex Research, Leuven, Belgium.
22. Cantor, J. M., Blak, T., Kuban, M. E., Klassen, P. E., Dickey, R. and Blanchard, R. (2007, October). *Physical height in pedophilia and hebephilia*. Poster presented at the 26th annual meeting of the Association for the Treatment of Sexual Abusers, San Diego.
23. Cantor, J. M., Blak, T., Kuban, M. E., Klassen, P. E., Dickey, R. and Blanchard, R. (2007, August). *Physical height in pedophilia and hebephilia*. Abstract and poster presented at the 33rd annual meeting of the International Academy of Sex Research, Vancouver, Canada.
24. Puts, D. A., Blanchard, R., Cardenas, R., Cantor, J., Jordan, C. L., & Breedlove, S. M. (2007, August). *Earlier puberty predicts superior performance on male-biased visuospatial tasks in men but not women*. Abstract and poster presented at the 33rd annual meeting of the International Academy of Sex Research, Vancouver, Canada.
25. Seto, M. C., Cantor, J. M., & Blanchard, R. (2005, November). *Possession of child pornography is a diagnostic indicator of pedophilia*. Poster presented at the 24th annual meeting of the Association for the Treatment of Sexual Abusers, New Orleans.

26. Blanchard, R., Cantor, J. M., Bogaert, A. F., Breedlove, S. M., & Ellis, L. (2005, July). *Interaction of fraternal birth order and handedness in the development of male homosexuality*. Abstract and poster presented at the 31st annual meeting of the International Academy of Sex Research, Ottawa, Canada.
27. Cantor, J. M., & Blanchard, R. (2003, July). *The reported VIQ–PIQ differences in male sex offenders are artifactual?* Abstract and poster presented at the 29th annual meeting of the International Academy of Sex Research, Bloomington, Indiana.
28. Christensen, B. K., Cantor, J. M., Millikin, C., & Blanchard, R. (2002, February). *Factor analysis of two brief memory tests: Preliminary evidence for modality-specific measurement*. Poster presented at the 30th annual meeting of the International Neuropsychological Society, Toronto, Ontario, Canada.
29. Cantor, J. M., Blanchard, R., Paterson, A., Bogaert, A. (2000, June). *How many gay men owe their sexual orientation to fraternal birth order?* Abstract and poster presented at the International Behavioral Development Symposium, Minot, North Dakota.
30. Cantor, J. M., Binik, Y., & Pfaus, J. G. (1996, November). *Fluoxetine inhibition of male rat sexual behavior: Reversal by oxytocin*. Poster presented at the 26th annual meeting of the Society for Neurosciences, Washington, DC.
31. Cantor, J. M., Binik, Y., & Pfaus, J. G. (1996, June). *An animal model of fluoxetine-induced sexual dysfunction: Dose dependence and time course*. Poster presented at the 28th annual Conference on Reproductive Behavior, Montréal, Canada.
32. Cantor, J. M., O'Connor, M. G., Kaplan, B., & Cermak, L. S. (1993, June). *Transient events test of retrograde memory: Performance of amnesic and unimpaired populations*. Poster presented at the 2nd annual science symposium of the Massachusetts Neuropsychological Society, Cambridge, MA.

EDITORIAL AND PEER-REVIEWING ACTIVITIES

Editor-in-Chief

Sexual Abuse: A Journal of Research and Treatment

Jan., 2010–Dec., 2014

Editorial Board Memberships

Journal of Sexual Aggression

Jan., 2010–Dec., 2021

Journal of Sex Research, The

Jan., 2008–Aug., 2020

Sexual Abuse: A Journal of Research and Treatment

Jan., 2006–Dec., 2019

Archives of Sexual Behavior

Jan., 2004–Present

The Clinical Psychologist

Jan., 2004–Dec., 2005

Ad hoc Journal Reviewer Activity

American Journal of Psychiatry

Annual Review of Sex Research

Archives of General Psychiatry

Assessment

Biological Psychiatry

BMC Psychiatry

Brain Structure and Function

British Journal of Psychiatry

British Medical Journal

Canadian Journal of Behavioural Science

Canadian Journal of Psychiatry

Cerebral Cortex

Clinical Case Studies

Comprehensive Psychiatry

Developmental Psychology

European Psychologist

Frontiers in Human Neuroscience

Human Brain Mapping

International Journal of Epidemiology

International Journal of Impotence Research

International Journal of Sexual Health

International Journal of Transgenderism

Journal of Abnormal Psychology

Journal of Clinical Psychology

Journal of Consulting and Clinical Psychology

Journal of Forensic Psychology Practice

Journal for the Scientific Study of Religion

Journal of Sexual Aggression

Journal of Sexual Medicine

Journal of Psychiatric Research

Nature Neuroscience

Neurobiology Reviews

Neuroscience & Biobehavioral Reviews

Neuroscience Letters

*Proceedings of the Royal Society B
(Biological Sciences)*

Psychological Assessment

Psychological Medicine

Psychological Science

Psychology of Men & Masculinity

Sex Roles

Sexual and Marital Therapy

Sexual and Relationship Therapy

Sexuality & Culture

Sexuality Research and Social Policy

The Clinical Psychologist

Traumatology

World Journal of Biological Psychiatry

GRANT REVIEW PANELS

2017–2021 Member, College of Reviewers, *Canadian Institutes of Health Research*, Canada.

2017 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2017 Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research]*, Germany.

2016 Reviewer. National Science Center [*Narodowe Centrum Nauki*], Poland.

2016 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2015 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council*, Australia.

2015 Reviewer. *Czech Science Foundation*, Czech Republic.

2015 Reviewer, “Off the beaten track” grant scheme. *Volkswagen Foundation*, Germany.

2015 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada

2015 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2014 Assessor (Peer Reviewer). Discovery Grants Program. *Australian Research Council*, Australia.

2014 External Reviewer, Discovery Grants program—Biological Systems and Functions. *National Sciences and Engineering Research Council of Canada*, Canada.

2014 Panel Member, Dean’s Fund—Clinical Science Panel. *University of Toronto Faculty of Medicine*, Canada.

2014 Committee Member, Peer Review Committee—Doctoral Research Awards A. *Canadian Institutes of Health Research*, Canada.

2013 Panel Member, Grant Miller Cancer Research Grant Panel. *University of Toronto Faculty of Medicine*, Canada.

- 2013 Panel Member, Dean of Medicine Fund New Faculty Grant Clinical Science Panel. *University of Toronto Faculty of Medicine*, Canada.
- 2012 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence (2nd round). *Bundesministerium für Bildung und Forschung [Ministry of Education and Research]*, Germany.
- 2012 External Reviewer, University of Ottawa Medical Research Fund. *University of Ottawa Department of Psychiatry*, Canada.
- 2012 External Reviewer, Behavioural Sciences—B. *Canadian Institutes of Health Research*, Canada.
- 2011 Board Member, International Review Board, Research collaborations on behavioural disorders related to violence, neglect, maltreatment and abuse in childhood and adolescence. *Bundesministerium für Bildung und Forschung [Ministry of Education and Research]*, Germany.

TEACHING AND TRAINING

PostDoctoral Research Supervision

Law & Mental Health Program, Centre for Addiction and Mental Health, Toronto, Canada

Dr. Katherine S. Sutton	Sept., 2012–Dec., 2013
Dr. Rachel Fazio	Sept., 2012–Aug., 2013
Dr. Amy Lykins	Sept., 2008–Nov., 2009

Doctoral Research Supervision

Centre for Addiction and Mental Health, Toronto, Canada

Michael Walton • University of New England, Australia	Sept., 2017–Aug., 2018
Debra Soh • York University	May, 2013–Aug., 2017
Skye Stephens • Ryerson University	April, 2012–June, 2016

Masters Research Supervision

Centre for Addiction and Mental Health, Toronto, Canada

Nicole Cormier • Ryerson University	June, 2012–present
Debra Soh • Ryerson University	May, 2009–April, 2010

Undergraduate Research Supervision

Centre for Addiction and Mental Health, Toronto, Canada

Kylie Reale • Ryerson University	Spring, 2014
Jarrett Hannah • University of Rochester	Summer, 2013
Michael Humeniuk • University of Toronto	Summer, 2012

Clinical Supervision (Doctoral Internship)

Clinical Internship Program, Centre for Addiction and Mental Health, Toronto, Canada

Katherine S. Sutton • Queen's University	2011–2012
David Sylva • Northwestern University	2011–2012
Jordan Rullo • University of Utah	2010–2011
Lea Thaler • University of Nevada, Las Vegas	2010–2011
Carolyn Klein • University of British Columbia	2009–2010
Bobby R. Walling • University of Manitoba	2009–2010

TEACHING AND TRAINING

Clinical Supervision (Doctoral- and Masters- level practica)
Centre for Addiction and Mental Health, Toronto, Canada

Tyler Tulloch • Ryerson University	2013–2014
Natalie Stratton • Ryerson University	Summer, 2013
Fiona Dyshniku • University of Windsor	Summer, 2013
Mackenzie Becker • McMaster University	Summer, 2013
Skye Stephens • Ryerson University	2012–2013
Vivian Nyantakyi • Capella University	2010–2011
Cailey Hartwick • University of Guelph	Fall, 2010
Tricia Teeft • Humber College	Summer, 2010
Allison Reeves • Ontario Institute for Studies in Education/Univ. of Toronto	2009–2010
Helen Bailey • Ryerson University	Summer, 2009
Edna Aryee • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Iryna Ivanova • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Jennifer Robinson • Ontario Institute for Studies in Education/Univ. of Toronto	2008–2009
Zoë Laksman • Adler School of Professional Psychology	2005–2006
Diana Mandelew • Adler School of Professional Psychology	2005–2006
Susan Wnuk • York University	2004–2005
Hiten Lad • Adler School of Professional Psychology	2004–2005
Natasha Williams • Adler School of Professional Psychology	2003–2004
Lisa Couperthwaite • Ontario Institute for Studies in Education/Univ. of Toronto	2003–2004
Lori Gray, née Robichaud • University of Windsor	Summer, 2003
Sandra Belfry • Ontario Institute for Studies in Education/Univ. of Toronto	2002–2003
Althea Monteiro • York University	Summer, 2002
Samantha Dworsky • York University	2001–2002
Kerry Collins • University of Windsor	Summer, 2001
Jennifer Fogarty • Waterloo University	2000–2001
Emily Cripps • Waterloo University	Summer, 2000
Lee Beckstead • University of Utah	2000

PROFESSIONAL SOCIETY ACTIVITIES

OFFICES HELD

2018–2019	Local Host. Society for Sex Therapy and Research.
2015	Member, International Scientific Committee, World Association for Sexual Health.
2015	Member, Program Planning and Conference Committee, Association for the Treatment of Sexual Abusers
2012–2013	Chair, Student Research Awards Committee, Society for Sex Therapy & Research
2012–2013	Member, Program Planning and Conference Committee, Association for the Treatment of Sexual Abusers
2011–2012	Chair, Student Research Awards Committee, Society for Sex Therapy & Research
2010–2011	Scientific Program Committee, International Academy of Sex Research
2002–2004	Membership Committee • APA Division 12 (Clinical Psychology)
2002–2003	Chair, Committee on Science Issues, APA Division 44
2002	Observer, Grant Review Committee • Canadian Institutes of Health Research Behavioural Sciences (B)
2001–2009	Reviewer • APA Division 44 Convention Program Committee
2001, 2002	Reviewer • APA Malyon-Smith Scholarship Committee
2000–2005	Task Force on Transgender Issues, APA Division 44
1998–1999	Consultant, APA Board of Directors Working Group on Psychology Marketplace
1997	Student Representative • APA Board of Professional Affairs' Institute on TeleHealth
1997–1998	Founder and Chair • APA/APAGS Task Force on New Psychologists' Concerns
1997–1999	Student Representative • APA/CAPP Sub-Committee for a National Strategy for Prescription Privileges
1997–1999	Liaison • APA Committee for the Advancement of Professional Practice
1997–1998	Liaison • APA Board of Professional Affairs
1993–1997	Founder and Chair • APA/APAGS Committee on LGB Concerns

PROFESSIONAL SOCIETY ACTIVITIES

MEMBERSHIPS

2017–2021 Member • *Canadian Sex Research Forum*

2009–Present Member • *Society for Sex Therapy and Research*

2006–Present Member (elected) • *International Academy of Sex Research*

2006–Present Research and Clinical Member • *Association for the Treatment of Sex Abusers*

2003–2006 Associate Member (elected) • *International Academy of Sex Research*

2002 Founding Member • CPA Section on Sexual Orientation and Gender Identity

2001–2013 Member • *Canadian Psychological Association (CPA)*

2000–2015 Member • *American Association for the Advancement of Science*

2000–2015 Member • *American Psychological Association (APA)*

APA Division 12 (Clinical Psychology)

APA Division 44 (Society for the Psychological Study of LGB Issues)

2000–2020 Member • *Society for the Scientific Study of Sexuality*

1995–2000 Student Member • *Society for the Scientific Study of Sexuality*

1993–2000 Student Affiliate • *American Psychological Association*

1990–1999 Member, American Psychological Association of Graduate Students (APAGS)

CLINICAL LICENSURE/REGISTRATION

Certificate of Registration, Number 3793
College of Psychologists of Ontario, Ontario, Canada

AWARDS AND HONORS

2017 Elected Fellow, Association for the Treatment of Sexual Abusers

2011 Howard E. Barbaree Award for Excellence in Research
Centre for Addiction and Mental Health, Law and Mental Health Program

2004 fMRI Visiting Fellowship Program at Massachusetts General Hospital
American Psychological Association Advanced Training Institute and NIH

1999–2001 CAMH Post-Doctoral Research Fellowship
Centre for Addiction and Mental Health Foundation and Ontario Ministry of Health

1998 Award for Distinguished Contribution by a Student
American Psychological Association, Division 44

1995 Dissertation Research Grant
Society for the Scientific Study of Sexuality

1994–1996 McGill University Doctoral Scholarship

1994 Award for Outstanding Contribution to Undergraduate Teaching
“TA of the Year Award,” from the McGill Psychology Undergraduate Student Association

MAJOR MEDIA

(Complete list available upon request.)

Feature-length Documentaries

Vice Canada Reports. [Age of Consent](#). 14 Jan 2017.

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25 Apr 2018. Yang, J. [Number cited in cryptic Facebook post matches Alek Minassian’s military ID: Source](#). *Toronto Star*.

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7 Nov 2017. Nazaryan, A. [Why is the alt-right obsessed with pedophilia?](#) *Newsweek*.

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11 Sep 2017. Burns, C. [The young paedophiles who say they don’t abuse children](#). *BBC News*.

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16 Aug 2017. Blackwell, Tom. [Man says he was cured of pedophilia at Ottawa clinic: ‘It’s like a weight that’s been lifted’: But skeptics worry about the impact of sending pedophiles into the world convinced their curse has been vanquished](#). *National Post*.

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LEGAL TESTIMONY, PAST 5 YEARS

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2022	BPJ v WV Board of Education	Southern District, West Virginia
2021	Cross et al. v Loudoun School Board	Loudoun, Virginia
2021	Allan M. Josephson v Neeli Bendapudi	Western District of Kentucky
2021	Re Commitment of Michael Hughes (Frye Hearing)	Cook County, Illinois
2019	US vs Peter Bright	Southern Dist. of New York, NY
2019	Probate and Family Court (Custody Hearing)	Boston, Massachusetts
2019	Re Commitment of Steven Casper (Frye Hearing)	Kendall County, Illinois
2019	Re Commitment of Inger (Frye Hearing)	Poughkeepsie, New York
2018	Re Commitment of Fernando Little (Frye Hearing)	Utica, New York
2018	Canada vs John Fitzpatrick (Sentencing Hearing)	Toronto, Ontario, Canada



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Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy

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ABSTRACT

The American Academy of Pediatrics (AAP) recently published a policy statement: *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents*. Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping gender diverse (GD) children, the AAP statement instead rejected that consensus, endorsing *gender affirmation* as the only acceptable approach. Remarkably, not only did the AAP statement fail to include any of the actual outcomes literature on such cases, but it also misrepresented the contents of its citations, which repeatedly said the very opposite of what AAP attributed to them.

The American Academy of Pediatrics (AAP) recently published a policy statement entitled, *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents* (Rafferty, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, 2018). These are children who manifest discontent with the sex they were born as and desire to live as the other sex (or as some alternative gender role). The policy was quite a remarkable document: Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping transgender and gender diverse (GD) children, the AAP statement rejected that consensus, endorsing only *gender affirmation*. That is, where the consensus is to delay any transitions after the onset of puberty, AAP instead rejected waiting before transition. With AAP taking such a dramatic departure from other professional associations, I was immediately curious about what evidence led them to that conclusion. As I read the works on which they based their policy, however, I was pretty surprised—rather alarmed, actually: These documents simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing *watchful waiting*.

The AAP statement was also remarkable in what it left out—namely, the actual outcomes research on GD children. In total, there have been 11 follow-up studies of GD children, of which AAP cited one (Wallien & Cohen-Kettenis, 2008), doing so without actually mentioning the outcome data it contained. The literature on outcomes was neither reviewed, summarized, nor subjected to meta-analysis to be considered in the aggregate—It was merely disappeared. (The list of all existing studies appears in the appendix.) As they make clear, *every* follow-up study of GD children, without exception, found the same thing: Over puberty, the majority of GD children cease to want to transition. AAP is, of course, free to establish whatever policy it likes on

whatever basis it likes. But any assertion that their policy is based on evidence is demonstrably false, as detailed below.

AAP divided clinical approaches into three types—conversion therapy, watchful waiting, and gender affirmation. It rejected the first two and endorsed *gender affirmation* as the only acceptable alternative. Most readers will likely be familiar already with attempts to use conversion therapy to change sexual orientation. With regard to gender identity, AAP wrote:

“[C]onversion” or “reparative” treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions.... Reparative approaches have been proven to be not only unsuccessful³⁸ but also deleterious and are considered outside the mainstream of traditional medical practice.^{29,39–42}

The citations were:

38. Haldeman DC. The practice and ethics of sexual orientation conversion therapy. *J Consult Clin Psychol.* 1994;62(2):221–227.
29. Adelson SL; American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *J Am Acad Child Adolesc Psychiatry.* 2012;51(9):957–974.
39. Byne W. Regulations restrict practice of conversion therapy. *LGBT Health.* 2016;3(2):97–99.
40. Cohen-Kettenis PT, Delemarrevan de Waal HA, Gooren LJ. The treatment of adolescent transsexuals: changing insights. *J Sex Med.* 2008;5(8):1892–1897.
41. Bryant K. Making gender identity disorder of childhood: historical lessons for contemporary debates. *Sex Res Soc Policy.* 2006;3(3):23–39.
42. World Professional Association for Transgender Health. *WPATH De-Psychopathologisation Statement.* Minneapolis, MN: World Professional Association for Transgender Health; 2010.

AAP’s claims struck me as odd because *there are no studies of conversion therapy for gender identity*. Studies of conversion therapy have been limited to *sexual orientation*, and, moreover, to the sexual orientation of *adults*, not to gender identity and not of children in any case. The article AAP cited to support their claim (reference number 38) is indeed a classic and well-known review, but it is a review of sexual orientation research *only*. Neither gender identity, nor even children, received a single mention in it. Indeed, the narrower scope of that article should be clear to anyone reading even just its title: “The practice and ethics of *sexual orientation* conversion therapy” [italics added].

AAP continued, saying that conversion approaches for GD children have already been rejected by medical consensus, citing five sources. This claim struck me as just as odd, however—I recalled associations banning conversion therapy for sexual orientation, but not for gender identity, exactly because there is no evidence for generalizing from adult sexual orientation to childhood gender identity. So, I started checking AAP’s citations for that, and these sources too pertained only to sexual orientation, not gender identity (specifics below). What AAP’s sources *did* repeatedly emphasize was that:

- A. Sexual orientation of adults is unaffected by conversion therapy and any other [known] intervention;
- B. Gender dysphoria in childhood before puberty desists in the majority of cases, becoming (cis-gendered) homosexuality in adulthood, again regardless of any [known] intervention; and
- C. Gender dysphoria in childhood persisting after puberty tends to persist entirely.

That is, in the context of GD children, it simply makes no sense to refer to externally induced “conversion”: The majority of children “convert” to cisgender or “desist” from transgender

regardless of any attempt to change them. “Conversion” only makes sense with regard to adult sexual orientation because (unlike childhood gender identity), adult homosexuality never or nearly never spontaneously changes to heterosexuality. Although gender identity and sexual orientation may often be analogous and discussed together with regard to social or political values and to civil rights, they are nonetheless distinct—with distinct origins, needs, and responses to medical and mental health care choices. Although AAP emphasized to the reader that “gender identity is not synonymous with ‘sexual orientation’” (Rafferty et al., 2018, p. 3), they went ahead to treat them as such nonetheless.

To return to checking AAP’s fidelity to its sources: Reference 29 was a practice guideline from the Committee on Quality Issues of the American Academy of Child and Adolescent Psychiatry (AACAP). Despite AAP applying this source to *gender identity*, AACAP was quite unambiguous regarding their intent to speak to sexual orientation and *only* to sexual orientation: “Principle 6. Clinicians should be aware that there is no evidence that *sexual orientation* can be altered through therapy, and that attempts to do so may be harmful. There is no established evidence that change in a predominant, enduring *homosexual* pattern of development is possible. Although sexual fantasies can, to some degree, be suppressed or repressed by those who are ashamed of or in conflict about them, sexual desire is not a choice. However, behavior, social role, and—to a degree—identity and self-acceptance are. Although operant conditioning modifies sexual fetishes, it does not alter *homosexuality*. Psychiatric efforts to alter *sexual orientation* through ‘reparative therapy’ in adults have found little or no change in *sexual orientation*, while causing significant risk of harm to self-esteem” (AACAP, 2012, p. 967, italics added).

Whereas AAP cites AACAP to support gender affirmation as the only alternative for treating GD children, AACAP’s actual view was decidedly neutral, noting the lack of evidence: “Given the lack of empirical evidence from randomized, controlled trials of the efficacy of treatment aimed at eliminating gender discordance, the potential risks of treatment, and longitudinal evidence that gender discordance persists in only a small minority of untreated cases arising in childhood, further research is needed on predictors of persistence and desistence of childhood gender discordance as well as the long-term risks and benefits of intervention before any treatment to eliminate gender discordance can be endorsed” (AACAP, 2012, p. 969). Moreover, whereas AAP rejected watchful waiting, what AACAP recommended was: “In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood” (AACAP, 2012, p. 969). So, not only did AAP attribute to AACAP something AACAP never said, but also AAP withheld from readers AACAP’s actual view.

Next, in reference 39, Byne (2016) also addressed only sexual orientation, doing so very clearly: “Reparative therapy is a subset of conversion therapies based on the premise that *same-sex attraction* are reparations for childhood trauma. Thus, practitioners of reparative therapy believe that exploring, isolating, and repairing these childhood emotional wounds will often result in reducing *same-sex attractions*” (Byne, 2016, p. 97). Byne does not say this of gender identity, as the AAP statement misrepresents.

In AAP reference 40, Cohen-Kettenis et al. (2008) did finally pertain to gender identity; however, this article never mentions conversion therapy. (!) Rather, in this study, the authors presented that clinic’s lowering of their minimum age for cross-sex hormone treatment from age 18 to 16, which they did on the basis of a series of studies showing the high rates of success with this age group. Although it did strike me as odd that AAP picked as support against conversion therapy an article that did not mention conversion therapy, I could imagine AAP cited the article as an example of what the “mainstream of traditional medical practice” consists of (the logic being that conversion therapy falls outside what an ‘ideal’ clinic like this one provides). However, what this clinic provides is the very *watchful waiting* approach that AAP rejected. The approach

espoused by Cohen-Kettenis (and the other clinics mentioned in the source—Gent, Boston, Oslo, and now formerly, Toronto) is to make puberty-halting interventions available at age 12 because: “[P]ubertal suppression may give adolescents, together with the attending health professional, more time to explore their gender identity, without the distress of the developing secondary sex characteristics. The precision of the diagnosis may thus be improved” (Cohen-Kettenis et al., 2008, p. 1894).

Reference 41 presented a very interesting history spanning the 1960s–1990s about how feminine boys and tomboyish girls came to be recognized as mostly pre-homosexual, and how that status came to be entered into the DSM at the same time as homosexuality was being *removed* from the DSM. Conversion therapy is never mentioned. Indeed, to the extent that Bryant mentions treatment at all, it is to say that treatment is entirely irrelevant to his analysis: “An important omission from the *DSM* is a discussion of the kinds of treatment that GIDC children should receive. (This omission is a general orientation of the *DSM* and not unique to GIDC)” (Bryant, 2006, p. 35). How this article supports AAP’s claim is a mystery. Moreover, how AAP could cite a 2006 history discussing events of the 1990s and earlier to support a claim about the *current* consensus in this quickly evolving discussion remains all the more unfathomable.

Cited last in this section was a one-paragraph press release from the World Professional Association for Transgender Health. Written during the early stages of the American Psychiatric Association’s (APA’s) update of the *DSM*, the statement asserted simply that “The WPATH Board of Directors strongly urges the de-psychopathologisation of gender variance worldwide.” Very reasonable debate can (and should) be had regarding whether gender dysphoria should be removed from the *DSM* as homosexuality was, and WPATH was well within its purview to assert that it should. Now that the *DSM* revision process is years completed however, history has seen that APA ultimately retained the diagnostic categories, rejecting WPATH’s urging. This makes AAP’s logic entirely backwards: That WPATH’s request to depathologize gender dysphoria was *rejected* suggests that it is WPATH’s view—and therefore the AAP policy—which fall “outside the mainstream of traditional medical practice.” (!)

AAP based this entire line of reasoning on their belief that conversion therapy is being used “to prevent children and adolescents from identifying as transgender” (Rafferty et al., 2018, p. 4). That claim is left without citation or support. In contrast, what is said by AAP’s sources is “delaying affirmation should *not* be construed as conversion therapy or an attempt to change gender identity” in the first place (Byne, 2016, p. 2). Nonetheless, AAP seems to be doing exactly that: simply relabeling any alternative approach as equivalent to conversion therapy.

Although AAP (and anyone else) may reject (what they label to be) conversion therapy purely on the basis of political or personal values, there is no evidence to back the AAP’s stated claim about the existing science on gender identity at all, never mind gender identity of children.

AAP also dismissed the watchful waiting approach out of hand, not citing any evidence, but repeatedly calling it “outdated.” The criticisms AAP provided, however, again defied the existing evidence, with even its own sources repeatedly calling watchful waiting the current standard. According to AAP:

[G]ender affirmation is in contrast to the outdated approach in which a child’s gender-diverse assertions are held as “possibly true” until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed “watchful waiting.” This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment (“desisters”).^{45,47}

The citations from AAP’s reference list are:

45. Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Keo-Meier C. Prepubertal social gender transitions: what we know; what we can learn—a view from a gender affirmative lens. *Int J Transgend*. 2018;19(2):251–268
47. Olson KR. Prepubescent transgender children: what we do and do not know. *J Am Acad Child Adolesc Psychiatry*. 2016;55(3):155–156.e3

I was surprised first by the AAP's claim that watchful waiting's delay to puberty was somehow "arbitrary." The literature, including AAP's sources, repeatedly indicated the pivotal importance of puberty, noting that outcomes strongly diverge at that point. According to AAP reference 29, in "*prepubertal* boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2% to 11.9% continuing to experience gender discordance" (Adelson & AACAP, 2012, p. 963, italics added), whereas "when gender variance with the desire to be the other sex is present *in adolescence*, this desire usually does persist through adulthood" (Adelson & AACAP, 2012, p. 964, italics added). Similarly, according to AAP reference 40, "Symptoms of GID *at prepubertal ages* decrease or even disappear in a considerable percentage of children (estimates range from 80–95%). Therefore, any intervention in childhood would seem premature and inappropriate. However, GID persisting *into early puberty* appears to be highly persistent" (Cohen-Kettenis et al., 2008, p. 1895, italics added). That follow-up studies of prepubertal transition differ from postpubertal transition is the very meaning of non-arbitrary. AAP gave readers exactly the reverse of what was contained in its own sources. If AAP were correct in saying that puberty is an arbitrarily selected age, then AAP will be able to offer another point to wait for with as much empirical backing as puberty has.

Next, it was not clear on what basis AAP could say that watchful waiting withholds support—AAP cited no support for its claim. The people in such programs often receive substantial support during this period. Also unclear is on what basis AAP could already know exactly which treatments are "critical" and which are not—Answering that question is the very purpose of this entire endeavor. Indeed, the logic of AAP's claim appears entirely circular: It is only if one were already pre-convinced that gender affirmation is the only acceptable alternative that would make watchful waiting seem to withhold critical support—What it delays is gender affirmation, the method one has already decided to be critical.

Although AAP's next claim did not have a citation appearing at the end of its sentence, binary notions of gender were mentioned both in references 45 and 47. Specifically, both pointed out that existing outcome studies have been about people transitioning from one sex to the other, rather than from one sex to an in-between status or a combination of masculine/feminine features. Neither reference presented this as a reason to reject the results from the existing studies of complete transition however (which is how AAP cast it). Although it is indeed true that the outcome data have been about complete transition, some future study showing that partial transition shows a different outcome would not invalidate what is known about complete transition. Indeed, data showing that partial transition gives better outcomes than complete transition would, once again, support the watchful waiting approach which AAP rejected.

Next was a vague reference alleging concerns and criticisms about early studies. Had AAP indicated what those alleged concerns and flaws were (or which studies they were), then it would be possible to evaluate or address them. Nonetheless, the argument is a red herring: Because all of the later studies showed the same result as did the early studies, any such allegation is necessarily moot.

Reference 47 was a one-and-a-half page commentary in which the author off-handedly mentions criticisms previously made of three of the eleven outcome studies of GD children, but does not provide any analysis or discussion. The only specific claim was that studies (whether early or late) had limited follow-up periods—the logic being that had outcome researchers lengthened the follow-up period, then people who seemed to have desisted might have returned to the clinic as

cases of “persistence-after-interruption.” Although one could debate the merits of that prediction, AAP instead simply withheld from the reader the result from the original researchers having tested that very prediction directly: Steensma and Cohen-Kettenis (2015) conducted another analysis of their cohort, by then ages 19–28 (mean age 25.9 years), and found that 3.3% (5 people of the sample of 150) later returned. That is, in long-term follow-up, the childhood sample showed 66.7% desistence instead of 70.0% desistance.

Reference 45 did not support the claim that watchful-waiting is “outdated” either. Indeed, that source said the very opposite, explicitly referring to watchful waiting as the *current* approach: “Put another way, if clinicians are straying from SOC 7 guidelines for social transitions, not abiding by the watchful waiting model *avored by the standards*, we will have adolescents who have been consistently living in their affirmed gender since age 3, 4, or 5” (Ehrensaft et al., 2018, p. 255). Moreover, Ehrensaft et al. said there are cases in which they too would still use watchful waiting: “When a child’s gender identity is unclear, the watchful waiting approach can give the child and their family time to develop a clearer understanding and is not necessarily in contrast to the needs of the child” (p. 259). Ehrensaft et al. are indeed critical of the watchful waiting model (which they feel is applied too conservatively), but they do not come close to the position the AAP policy espouses. Where Ehrensaft summarizes the potential benefits and potential risks both to transitioning and not transitioning, the AAP presents an ironically binary narrative.

In its policy statement, AAP told neither the truth nor the whole truth, committing sins both of commission and of omission, asserting claims easily falsified by anyone caring to do any fact-checking at all. AAP claimed, “This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population”; however, much of that evidence was about sexual orientation, not gender identity. AAP claimed, “Current available research and expert opinion from clinical and research leaders...will serve as the basis for recommendations” (pp. 1–2); however, they provided recommendations entirely unsupported and even in direct opposition to that research and opinion.

AAP is advocating for something far in excess of mainstream practice and medical consensus. In the presence of compelling evidence, that is just what is called for. The problems with Rafferty, however, do not constitute merely a misquote, a misinterpretation of an ambiguous statement, or a missing reference or two. Rather, AAP’s statement is a systematic exclusion and misrepresentation of entire literatures. Not only did AAP fail to provide compelling evidence, it failed to provide the evidence at all. Indeed, AAP’s recommendations are *despite* the existing evidence.

Disclosure statement

No potential conflict of interest was reported by the author.

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Appendix

Count	Group	Study
2/16	gay*	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome.
4/16	trans-/crossdress	<i>American Journal of Psychiatry</i> , 128, 1283–1289.
10/16	straight*/uncertain	
2/16	trans-	Zuger, B. (1978). Effeminate behavior present in boys from childhood:
2/16	uncertain	Ten additional years of follow-up. <i>Comprehensive Psychiatry</i> , 19, 363–369.
12/16	gay	
0/9	trans-	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant
9/9	gay	gender identity/role: Longitudinal follow-up. <i>Journal of Pediatric Psychology</i> , 4, 29–41.
2/45	trans-/crossdress	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and
10/45	uncertain	significance for homosexuality. <i>Journal of Nervous and Mental Disease</i> , 172, 90–97.
33/45	gay	
1/10	trans-	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. <i>Archives of</i>
2/10	gay	<i>Sexual Behavior</i> , 15, 511–517.
3/10	uncertain	
4/10	straight	
1/44	trans-	Green, R. (1987). <i>The "sissy boy syndrome" and the development of homosexuality</i> .
43/44	cis-	New Haven, CT: Yale University Press.
0/8	trans-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help?
8/8	cis-	<i>Medical Journal of Australia</i> , 146, 565–569.
21/54	trans-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric
33/54	cis-	children. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i> , 47, 1413–1423.
3/25	trans-	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study
6/25	lesbian/bi-	of girls with gender identity disorder. <i>Developmental Psychology</i> , 44, 34–45.
16/25	straight	
17/139	trans-	Singh, D. (2012). <i>A follow-up study of boys with gender identity disorder</i> . Unpublished doctoral
122/139	cis-	dissertation, University of Toronto.
47/127	trans-	Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013).
80/127	cis-	Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i> , 52, 582–590.

*For brevity, the list uses "gay" for "gay and cis-", "straight" for "straight and cis-", etc.

DOC. 69-3

**UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION**

REV. PAUL A. EKNES-TUCKER,	)	
<i>et al.</i> ,	)	
	)	
<i>Plaintiffs</i> ,	)	
	)	
v.	)	No. 2:22-cv-00184-LCB-SRW
	)	
KAY IVEY, in her official capacity	)	
as Governor of the State of Alabama,	)	
<i>et al.</i> ,	)	
	)	
<i>Defendants.</i>	)	

DECLARATION OF MICHAEL K. LAIDLAW, M.D.

My name is Michael K. Laidlaw. I am over the age of 19, I am qualified to give this declaration, and, I have personal knowledge of the matters set forth herein.

I am a physician with specialties in endocrinology and internal medicine. I received a Bachelor of Science Degree in Biology with concentration in Molecular Cell Biology in 1997. I received my medical degree from the University of Southern California in 2001. I completed my residency in internal medicine at Los Angeles County/University of Southern California Medical Center in 2004. I also completed a fellowship in endocrinology, diabetes and metabolism at Los Angeles County/University of Southern California Medical Center in 2006.

The information provided regarding my professional background are detailed in my curriculum vitae attached as Exhibit A.

I have been practicing endocrinology in private practice in Rocklin, CA for the past 15 years. In my clinical practice as an endocrinologist, I evaluate patients with hormone excess, hormone deficiency, and other glandular disorders. These conditions result in numerous physical and psychological manifestations which I diagnose and treat.

I first began writing about gender dysphoria and the harms of gender affirmative therapy in a letter I sent to a local school board in Newcastle, California in January of 2018. I

voiced my concerns regarding misinformation and pertinent omissions in a book read in school entitled "I am Jazz" which is a children's book that discusses gender identity. These concerns were later published in The Public Discourse in an essay entitled "Gender Dysphoria and Children: An Endocrinologist's Evaluation of I am Jazz". (Laidlaw, 2018).

In 2019, I coauthored, along with four of my physician colleagues, a letter to the editor published in the Journal of Clinical Endocrinology and Metabolism, "Letter to the Editor: Endocrine Treatment of Gender-Dysphoria/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," in which we voiced our serious concerns with gender affirmative therapy (GAT) (Laidlaw, 2019).

In May of 2019 I spoke in the U.K.'s House of Lords at the invitation of Lord Lewis Moonie. The title of my speech was "Medical Harms Associated with the Hormonal and Surgical Therapy of Child and Adolescent Gender Dysphoria".

My recent publications include a letter to the editor of JCEM published in December 2021 "Erythrocytosis in a Large Cohort of Trans Men Using Testosterone: A Long-Term Follow-Up Study on Prevalence, Determinants, and Exposure Years."; "Gender affirmation surgery conclusion lacks evidence (letter)" published in the American Journal of Psychiatry in 2020; and "The Right to Best Care for Children Does Not Include the Right to Medical Transition" published in The American Journal of Bioethics in 2019. Other publications and Amicus Curiae Briefs are listed on my CV.

In the past four years, I have provided expert testimony in the following cases: JULIANA PAOLI v. JOSEPH HUDSON et al. heard in THE SUPERIOR COURT OF THE STATE OF CALIFORNIA, COUNTY OF TULARE. CASE NO. 279126. 2021; United States District Court for the District of Arizona. DH and John Doe, Plaintiffs, vs. Jami Snyder, Director of the Arizona Health Care Cost Containment System, in her official capacity, Defendant. Case No. 4:20-cv-00335-SHR. 2020; Supreme Court of British Columbia. File No. S2011599, Vancouver Registry. Between A.M. Plaintiff and Dr. F and Daniel McKee Defendants. 11/23/20 & 11/25/20; and Court of Appeal File No. CA45940, Vancouver Registry. B.C. Canada. Supreme Court File No. E190334, between A.B. Respondent/Claimant, and C.D. Appellant/Respondent, and E.F. Respondent/Respondent. 24 Jun 2019.

I have been retained by Defendant in the above-captioned lawsuit to provide an expert opinion on the medical soundness of the Alabama Vulnerable Child Compassion and Protection Act. The opinions expressed are based on my experience and education, a

review of the complaint and expert reports submitted by the plaintiffs, and the literature cited below.

I am compensated at the rate of \$450 per hour for my analysis, study, consultations, and preparation of expert reports, \$650 per hour for testifying in court or deposition, and \$250 per hour for travel. My compensation is not dependent upon the substance of my opinions or the outcome of the case.

A. Endocrine Disorders

Before discussing gender dysphoria and gender affirmative therapy from the perspective of an endocrinologist, it is helpful to discuss the background of endocrine diseases. This background demonstrates the difference in gender dysphoria, which is a psychological diagnosis, and other conditions treated by endocrinologists, which are physical diagnoses.

Endocrinology is the study of glands and hormones. Endocrine disorders can be divided into three main types: those that involve hormone excess, those that involve hormone deficiency, and those that involve structural abnormalities of the glands such as cancers.

It is important for the endocrinologist to determine the cause of hormone gland excess or deficiency in order to devise an appropriate treatment plan. The plan will generally be to help bring the hormones back into balance and thus bring the patient back to health.

To give an example of hormone excess, hyperthyroidism is a term which means overactivity of the thyroid gland. In this condition excess thyroid hormone is produced by the thyroid gland. This results in various physical and psychological changes for the afflicted patient. Examples of physical changes can include tachycardia or fast heart rate, hand tremors, and weight loss. Examples of psychological symptoms include anxiety, panic attacks, and sometimes even psychosis.

An endocrinologist can recognize thyroid hormone excess in part by signs and symptoms, but can also confirm the diagnosis with laboratory testing that shows the thyroid hormones to be out of balance. Once this is determined and the degree of excess is known, then treatments can be given to bring these levels back into balance to benefit the patient's health and to prevent other disease effects caused by excess hormone.

To give another example, consider a deficiency of insulin. Insulin is a hormone which regulates blood glucose levels. If there is damage to the pancreas such that insulin levels are very low, then blood glucose levels will rise. If the glucose levels rise to a certain abnormally high level, then this is considered diabetes. In the case of type 1 diabetes, insulin levels are abnormally low and therefore blood glucose levels are abnormally high leading to a variety of signs and symptoms. For example, the patient may have extreme thirst, frequent urination, muscle wasting, and weight loss. They may often experience lethargy and weakness.

In this case laboratory tests of glucose and insulin levels can confirm the diagnosis. Once diabetes is confirmed, the patient is then treated with insulin to help restore glucose balance in the body and prevent long term complications of diabetes.

To give an example of a structural abnormality, a patient may have a lump on the thyroid gland in the neck. This may be further examined by an imaging test such as an ultrasound. A needle biopsy can be performed so that the cells can be examined under a microscope. A trained medical professional such as a pathologist can then examine the cells to determine if they are benign or cancerous. In the case of a thyroid cancer, a surgical procedure known as a thyroidectomy may be performed to remove the diseased thyroid gland in order to treat the cancer.

Noteworthy in the preceding three examples is that all three disease conditions are diagnosed by physical observations. In other words, a laboratory test of a hormone, an imaging test of an organ, an examination of cells under a microscope, or all three may be employed in the diagnosis of endocrine disease.

B. Gender Dysphoria is a Psychological Diagnosis

Gender dysphoria, on the other hand, is not an endocrine diagnosis, it is in fact a psychological diagnosis. It is diagnosed purely by psychological methods of behavioral observation and questioning.

Likewise what is termed gender identity is a psychological concept. It has no correlate in the human body. In the letter to the editor I wrote with my colleagues, discussed above, we wrote in our critique of the Endocrine Society Guidelines that "There are no laboratory, imaging, or other objective tests to diagnose a 'true transgender' child" (Laidlaw et al., 2019).

For example, one cannot do imaging of the human brain to find the gender identity. Likewise, there is no other imaging, laboratory tests, biopsy of tissue, autopsy of the

brain, or genetic testing that can identify the gender identity. There is no known gene that maps to gender identity or to gender dysphoria. In other words, there is no objective physical measure to identify either gender identity or gender dysphoria.

This is in contrast to all other endocrine disorders which have a measurable physical change in either hormone levels or gland structure which can be confirmed by physical testing. Therefore, gender dysphoria is a purely psychological phenomenon and not an endocrine disorder. But as my colleagues and I wrote in our letter to the editor, it becomes an endocrine condition through gender affirmative therapy: "Childhood gender dysphoria (GD) is not an endocrine condition, but it becomes one through iatrogenic puberty blockade (PB) and high-dose cross-sex (HDCS) hormones. The consequences of this gender-affirmative therapy (GAT) are not trivial and include potential sterility, sexual dysfunction, thromboembolic and cardiovascular disease, and malignancy" (Laidlaw, et al. 2019).

C. Gender Dysphoria and Desistance

Gender dysphoria is a persistent state of distress that stems from the feeling that one's gender identity does not align with their physical sex (American Psychiatric Association, 2013). It has been a relatively rare condition in children and adolescents. However there have been very significant increases in referrals for this condition noted around the globe.

For example, in the UK, "The number of referrals to GIDS [Gender Identity Development Service] has increased very significantly in recent years. In 2009, 97 children and young people were referred. In 2018 that number was 2519" (Bell v Tavistock Judgment, 2020). There has been suggestion from parental reports that this increase may be in part due to social contagion and fueled by social media/internet use (Littman, 2018).¹

In "a study of the Finnish gender identity service, '75% of adolescents [assessed] had been or were currently undergoing child and adolescent psychiatric treatment for reasons other than gender dysphoria' (Kaltiala-Heino, 2015). In fact, '68% had their first contact with psychiatric services due to other reasons than gender identity issues.' The same study also showed that 26% percent had an autistic spectrum disorder and that a

¹ The French National Academy of Medicine wrote recently: "Parents addressing their children's questions about transgender identity or associated distress should remain vigilant regarding the addictive role of excessive engagement with social media, which is both harmful to the psychological development of young people and is responsible for a very significant part of the growing sense of gender incongruence" (SEGM, 2022).

disproportionate number of females (87%) were presenting to the gender clinics compared to the past” (Laidlaw in gdworkinggroup.org, 2018).

Desistance is a term indicating that the child, adolescent, or adult who initially presented with gender incongruence has come to experience a realignment of their internal sense of gender and their physical body. “Children with [gender dysphoria] will outgrow this condition in 61% to 98% of cases by adulthood. There is currently no way to predict who will desist and who will remain dysphoric” (Laidlaw et al. 2019).

Because there is no physical marker to diagnose gender identity, and because it is not possible to predict which child or adolescent will desist, it is not possible to know which young person will remain transgender identified as adults. Also, because the rate of desistance is so high, gender affirmative therapy will necessarily cause serious and irreversible harms to many children and adolescents.

D. Biological Sex in Contrast to Gender Identity

Biological sex is the objective physical condition of having organs and body parts which correspond to a binary sex. There are only two physical sexes, male and female. The male is identified as having organs and tissues such as the penis, testicles and scrotum. The female sex is identified by having organs and tissues such as the labia, vagina, uterus, and ovaries. Biological sex is easily identified by physical observation such that adults and even children of say four years old can identify the biological sex of a newborn baby.

This is in contrast to gender identity, which as mentioned does not exist in any physical sense. It is a subjective identification known only once a patient makes it known. It cannot be identified by any physical means, cannot be confirmed by any outside observer, and can change over time.

It is also noteworthy that the physical organs described above as representing biological sex have a physical genetic correlate. In other words, it is a well-established scientific fact that two X chromosomes identify the cells correlating to a female person, and an X and a Y chromosome correlate to a male person.

Sex is clearly identified in 99.98% of cases by chromosomal analysis (Sax, 2002). Sex is also clearly identified at birth in 99.98% of cases (Sax, 2002). Therefore, sex is a clear provable objective reality that can be identified through advanced testing such as karyotyping, or simple genital identification at birth by any layperson. The other 0.02%

of cases have some disorder of sexual development. These do not represent an additional sex or sexes, but simply a disorder on the way to binary sex development. These conditions are not related to the diagnosis of gender dysphoria.

1. Embryologic development

Another confirmation that there are only two biological sexes comes from what is known about embryologic development and fertilization. The biologic development of the human person begins with a gamete from a female termed an ovum or egg and a gamete from a biological male which is termed sperm. The fertilization of the egg by the sperm begins the process of human biological development. The cells of the fertilized ovum then multiply and the person undergoes the incredible changes of embryologic development.

It is noteworthy that the male sperm comes from the biological male and the female egg comes from the biological female. There is no other third or fourth or fifth type of gamete that exists to begin the development of the human person. This is consistent with the binary nature of human sex.

The sex binary of the human embryo is further developed between roughly weeks 8 to 12 of human development. There are two primitive structures present within the developing embryo called the Wolffian duct and Mullerian ducts (Larsen et al., 2003). The Wolffian ducts develop into substructures of the genitalia including the vas deferens and epididymis which belong exclusively to the male sex. For the female, the Mullerian ducts go on to form the uterus, fallopian tubes, cervix and upper one third of the vagina which belong exclusively to the female sex.

Significantly once the male structures are developed from Wolffian ducts, the Mullerian ducts are obliterated. This means that throughout the rest of embryological development the Mullerian ducts will not form into biological female structures. Likewise, in the female, the Wolffian ducts are destroyed by week 12 and will not form male structures at any point in the future.²

Thus we can see in very early development that the sex binary is imprinted physically not only in the chromosomes, but also on the very organs that the body produces. Additionally, the potential to develop organs of the opposite sex is eliminated. Thus, in the human being there are only two physical tracts that one may progress along, the one being male and the other being female.

² Excepting disorders of sexual development, which are unrelated to the diagnosis of gender dysphoria.

2. Pubertal development

As mentioned previously, at the time of birth an infant's sex is easily identified through observation of the genitalia. Corresponding internal structures could also be confirmed through imaging if needed.

In early childhood, some low level of sex hormones are produced by the sex glands. The male testes produce testosterone. The female ovaries produce primarily the hormone estrogen. These sex glands remain quiescent for the most part, producing low levels of sex hormones until the time of pubertal development.

Puberty is a time of development of the sex organs, body, brain and mind. There are well known changes in physical characteristics of the male such as growth of facial hair, deepening of the voice, and increasing size of the testicles and penis. Importantly the testicles will develop sperm under the influence of testosterone and become capable of ejaculation. Because of these changes, the male will become capable of fertilizing an egg. The inability to produce sperm sufficient to fertilize an egg is termed infertility.

For the female, pubertal development includes changes such as breast development, widening of the pelvis, and menstruation. The female will also begin the process of ovulation which is a part of the menstrual cycle and involves the release of an egg or eggs from the ovary. Once the eggs are released in a manner in which they can become fertilized by human sperm, the female is termed fertile. The inability to release ovum that can be fertilized is infertility. These concepts will become important later on when discussing puberty blockers and opposite sex hormones.

Puberty is also the time of social development when one changes schools appropriate for maturity such as middle school and high school. Groups of kids are placed together in such a way that they will develop with in concert their peers. This timing corresponds to the physical changes of sexual development during puberty.

It is psychologically important for similarly developing kids to be grouped together as they will have similar shared experiences and can continue to grow physically, emotionally, and psychologically through the dramatic changes that occur during puberty.

3. Tanner stages of development

From a medical perspective it is important to know the stage of pubertal development of the developing adolescent. This can be determined through a physical examination of the body. The female will have changes in breast characteristics and pubic hair development. Similarly, the male will have changes in testicular size and pubic hair development. These findings can be compared to the Tanner staging system which will allow the stage of puberty to be known.

Tanner stages are divided into five. Stage 1 is the pre-pubertal state before pubertal development of the child begins. Stage 5 is full adult sexual maturity. Stages 2 through 4 are various phases of pubertal development (Greenspan and Gardner, 2004).

Awareness of the Tanner stage of the developing adolescent is also useful to assess for maturation of sex organ development leading to fertility. For girls, menstruation and ovulation occurs about two years after Tanner stage 2 and will typically be at Tanner stage 4 or possibly 3 (Emmanuel and Boker, 2022). For boys, the first appearance of sperm is typically Tanner Stage 4 (Emmanuel and Bokor, 2022). If puberty is blocked before reaching these critical stages, the sex glands will be locked in a premature state and incapable of fertility.

These concepts will be very important later when discussing puberty blockers and opposite sex hormones.

4. Biological Sex Cannot Be Changed

It is not possible for a person to change from one biological sex to the other, and there is no technology that allows a biological male to become a biological female or vice-versa. It is not technologically possible at this time to change sex chromosomes; these will remain in every cell throughout life. It is not technologically possible to transform sex glands from one to the other. In other words, there are no hormones or other means currently known to change an ovary into a testicle or a testicle into an ovary.

Furthermore, as noted earlier, several of the sex specific structures (such as the epidymis of the male or uterus of the female) are produced early in embryological development from around weeks 8 to 12. The primitive ducts which lead to these organs of the opposite sex are obliterated. There is no known way to resuscitate these ducts and continue development of opposite sex structures.

It is also not possible to produce gametes of the opposite sex. In other words, there is not any known way to induce the testicles to produce eggs. Nor is there any known way to induce the ovaries to produce sperm. Therefore, creating conditions for a biological female to create sperm capable of fertilizing another ovum is impossible. Likewise in the human male testicle cannot be induced to create eggs. The induction of opposite sex fertility is impossible.

In fact, as I will discuss, gender affirming therapy actually leads to infertility and potential sterilization.

E. Iatrogenic Harms

The term iatrogenic is used in medicine to describe harms or newly created medical conditions that are the result of medications, surgeries, or even psychological treatments. In this section I will discuss the iatrogenic harms of "gender affirmative treatment," which includes treatment addressed by Alabama's law. Each of the four interventions which I will describe (social transition, puberty blockers, opposite sex hormones, and surgery) lead to iatrogenic harms to the patient. These harms will be described in detail below.

1. Gender Affirmative Therapy

The approaches to gender dysphoria may be divided into three main types. (Zucker, 2020). One is psychosocial treatment that helps the young person align their internal sense of gender with their physical sex. Another would be to "watch and wait" and allow time and maturity to help the young person to align sex and gender through natural desistance. The third option, which is the focus of that which follows, is referred to as gender affirmative therapy.

Gender affirmative therapy (GAT) consists of psychosocial, medical, and surgical interventions that attempt to psychologically and medically alter the patient so that they come to believe that they may become similar to the physical sex which aligns with their gender identity (but not their biological sex) and thereby reduce gender dysphoria. GAT consists of four main parts: 1) social transition, 2) blocking normal puberty, 3) high dose opposite sex hormones, and 4) surgery of the genitalia and breasts.

The application of this medical therapy to minors is a fairly new intervention and is associated with a number of harms both known and unknown. GAT suffers from a lack

of a quality evidence-base, poorly performed studies, and ongoing unethical human experimentation.

2. Social transition

The first stage of gender affirmative therapy is termed social transition. Social transition is a psychological intervention. The child may be encouraged to adopt the type of clothing and mannerisms or behaviors which are stereotypical of the opposite sex within a culture. For example, in the United States a boy might wear his hair long and wear dresses in order to socially transition. A girl may cut her hair short and wear clothes from the boys' section of a department store.

Social transition has been noted by expert researcher in the field of child gender dysphoria, Ken Zucker, to itself be a form of iatrogenic harm (Zucker, 2020). This insofar as the social transition process may solidify the young person's belief that they are in fact the sex opposite of that which was identified at birth.

It is easy to see why in the child's mind, by having the outward appearance of the opposite sex, that they would believe that they should have been destined to go through puberty of the opposite sex as they have only a poor understanding of the internal structures of the body, the function of the sex glands, the role of the sex glands in fertility and so forth.

Therefore, it would be quite frightening for a boy who believes he is a girl to be turning into a man with all of the adult features that accompany manhood. Vice versa, the girl who has become convinced that she is a boy will be frightened by the physical changes brought on by womanhood.

This is evident in the declaration of Megan Poe where she states: "Seeing Allison's response to the Alabama legislature's consideration of the Act and knowing how afraid she is of male puberty" (Megan Poe Declaration, 2022).

In fact it would appear that in the minds of the children and adolescents that they are anticipating a sort of disease state in the future by the hormone changes that will occur as a normal and natural part of human development. Until relatively recently in human history, it has not been possible to block puberty through pharmaceutical means.

3. Puberty blocking medication

The second step of the gender affirmative therapy model involves blocking normal pubertal development.

In order to understand what is occurring in this process, it is helpful to be aware of normal hormone function during pubertal development.

There is a small pea-sized gland in the brain called the pituitary. It is sometimes referred to as the "master gland" as it controls the function of several other glands. One key function for our purposes is the control of the sex glands. There are two specific hormones produced by the pituitary referred to as luteinizing hormone (LH) and follicle stimulating hormone (FSH). These are responsible for sex hormone production and fertility. The LH and FSH act as signals to tell the sex glands begin or continue their function.

In the adult male, the production of LH will cause adult levels of testosterone to be produced by the testicles. In the adult female, the production of LH will cause adult levels of estrogen to be produced by the ovaries.

In early childhood, prior to the beginning of puberty, the pituitary function with respect to the sex glands is quiescent. However, during pubertal development LH will signal the testicle to increase testosterone production and this carries the boy through the stages of pubertal development into manhood. Likewise for the female, the interaction of LH with the ovaries increases estrogen production and carries the girl through the stages of development into womanhood.

There are conditions diagnosed by the endocrinologist which involve a disruption of this normal communication between the pituitary and the sex glands. There is a medical condition called hypogonadotropic hypogonadism. The meaning of this term is that the pituitary is not sending the hormonal signals (LH and FSH) to the sex glands and therefore the sex glands are unable to make their sex hormones. The result is hormonal deficiencies of LH, FSH, and either testosterone or estrogen.

If this condition occurs during puberty, the effect will be to stop pubertal development. This is a disease state which is diagnosed and treated by the endocrinologist.

Medications such as GnRH agonists³ act on the pituitary gland to lower the pituitary release of LH and FSH levels dramatically. The result is a blockage of the signaling of

³ Gonadotropin Releasing Hormone agonists

the pituitary to the testicles or ovaries and therefore underproduction of the sex hormones. There are a variety of uses for GnRH agonists. The use and outcome can be very different for different applications.

For example, the initial development of the medication called Lupron was for the treatment of prostate cancer. The idea being that blocking pituitary hormones will block the adult male's release of testosterone from the testicles. Since testosterone will promote the growth of prostate cancer, the idea is to lower testosterone levels to a very low amount and therefore prevent the growth and spread of prostate cancer. This is a labeled use of the medication. In other words, there is FDA approval for this use.

Another labeled use of GnRH agonist medication is for the treatment of central precocious puberty. In the disease state of central precocious puberty, pituitary signaling is activated at an abnormally young age, say age four, to begin pubertal development. In order to halt puberty which has begun at an abnormally early time, a GnRH agonist may be used. Here the action of the medication on the pituitary will disrupt the signaling to the sex glands, stop early sex hormone production, and therefore stop abnormal pubertal development.

Then, at a more normal time of pubertal development, say age 11, the medication is stopped and puberty is allowed to proceed.⁴ The end result is to restore normal sex gland function and timing of puberty. This is a labeled use for a GnRH agonist medication.

What about the use of puberty blockers such as Lupron in gender affirmative therapy? In these cases, we have physiologically normal children who are just beginning puberty or are somewhere in the process of pubertal development. They have healthy pituitary glands and sex organs. However, a puberty blocking medication is administered to stop normal pubertal development.

In this case the condition of hypogonadotropic hypogonadism described above is induced medically and is an iatrogenic effect of treating the psychological condition of gender dysphoria. GnRH agonist medications have not been FDA approved for this use.

⁴ Once the medication is discontinued, it will take a number of months to a year or longer for the pituitary to regain its usual function.

4. Adverse Health Consequences of Blocking Normal Puberty

There are a number of serious health consequences that occur as the result of blocking normal puberty. The first problem is infertility. The Endocrine Society Guidelines recommend beginning puberty blockers as early as Tanner stage 2. As discussed earlier, this is the very beginning of puberty. Fertility development happens later generally in Tanner stage 4. One can see that if the developing person is blocked at Tanner stage 2 or 3 as advocated by the guidelines, this is prior to becoming fertile. The gonads will remain in an immature, undeveloped state.

This is why the guidelines refer to fertility preservation. However, studies show that less than 5% of adolescents receiving GAT even attempt fertility preservation (Nahata, 2017). Also fertility preservation for persons with immature ovaries and testicles is much more complicated, expensive and in many cases still experimental (Laidlaw, Cretella, et al. 2019).

Naturally, these children are at a developmental age where they are not thinking about adult related concepts such as having children as they are children themselves. This is only natural and to be expected. The medical problem imposed on them is that if they remain blocked in an early pubertal stage then even the addition of opposite sex hormones will not allow for the development of fertility. In fact, high dose opposite sex hormones may permanently damage the immature sex organs leading to sterilization. Certainly the removal of the gonads, which will be discussed later, will ensure sterilization.

Another problem with blocking puberty at an early stage is sexual dysfunction. The child will continue their chronological age progression toward adulthood and yet remain with undeveloped genitalia. This will lead to sexual dysfunction including potential erectile dysfunction and inability to ejaculate and orgasm for of the male. For the female with undeveloped genitalia potential sexual dysfunction may include painful intercourse and impairment of orgasm.

The impairment of sexual function was evident in the TLC reality show "I am Jazz". In the show Jazz who was identified male at birth has been given puberty blockers at an early pubertal stage. In an episode where Jazz visits a surgeon and has a discussion about sexual function, Jazz states: "I haven't experienced any sexual sensation." Regarding orgasm, Jazz says: "I don't know, I haven't experienced it"⁵ (TLC, accessed 2022).

⁵ Jazz's age is somewhere in the mid-teens during this episode.

In addition to direct effects on the developing genitalia and fertility there are other important aspects of puberty that are negatively affected. For example, puberty is a time of rapid bone development. This time of development is critical in attaining what we call peak bone density or the maximum bone density that one will acquire in their lifetime (Elhakeem, 2019).

Any abnormal lowering of sex hormones occurring during this critical time will stop the rapid accumulation of bone and therefore lower ultimate adult bone density. If a person does not achieve peak bone density, they would be expected to be at future risk for osteoporosis and the potential for debilitating spine and hip fractures as adults. Hip fractures for the older patient very significantly increase the risk of major morbidity and death (Bentler, 2009). Allowing a "pause" in puberty for any period of time leads to an inability to attain peak bone density.

Another consideration is maturation of the human brain. Much of what happens is actually unknown. However, "sex hormones including estrogen, progesterone, and testosterone can influence the development and maturation of the adolescent brain" (Arain, 2013). Therefore there are unknown, but likely negative consequences to blocking normal puberty with respect to brain development.

A third major problem with blocking normal puberty involves psychosocial development. Adolescence is a critical time of physical, mental, and emotional changes for the adolescent. It is important that they develop socially in conjunction with their peers. This is well recognized in the psychological literature: "For decades, scholars have pointed to peer relationships as one of the most important features of adolescence." (Brown, 2009). If one is left behind for several years under the impression that they are awaiting opposite sex puberty, they will miss important opportunities for socialization and psychological development. Psychosocial development will be necessarily stunted as they are not developing with their peers. This is a permanent harm as the time cannot be regained.

Aside from the multiple serious problems that are iatrogenically acquired by blocking normal puberty, there appear to be independent risks of the puberty blocking medication themselves. For example, one can read the labeling of a common puberty blocking medication called Lupron Depot-Ped and find under psychiatric disorders: "emotional lability, such as crying, irritability, impatience, anger, and aggression. Depression, including rare reports of suicidal ideation and attempt. Many, but not all, of these patients had a history of psychiatric illness or other comorbidities with an increased risk of depression" (Lupron, 2022). This is particularly concerning given the high rate of psychiatric comorbidity with gender dysphoria discussed previously.

5. The Effect of Puberty Blockers on Desistance

As stated earlier a very high proportion of minors diagnosed with gender dysphoria will eventually desist or come to accept their physical sex. Puberty blockers have been shown to dramatically alter natural desistance.

In a Dutch study that included seventy adolescents who took puberty blockers, all seventy decided to go on to hormones of the opposite sex (de Vries, et al. 2011). In a follow-up study, the majority went on to have sex reassignment surgery by either vaginoplasty for males or hysterectomy with ovariectomy for females (de Vries, et al. 2014). These surgeries resulted in sterilization. This is why puberty blockers, rather than being a “pause” to consider aspects of mental health, are instead a pathway towards future sterilizing surgeries.

6. Opposite Sex Hormones

The third stage of gender affirmative therapy involves using hormones of the opposite sex at high doses to attempt to create secondary sex characteristics in the person's body. Before beginning I will describe FDA approved usages of estrogen and testosterone

a. Testosterone

Testosterone is an anabolic steroid of high potency. It is classified as a Schedule 3 controlled substance by the DEA: "Substances in this schedule have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence" (DEA, 2022)

I prescribe testosterone to men for testosterone deficiency. The state of testosterone deficiency can cause various problems including problems of mood, sexual function, libido, and bone density. Prescription testosterone is given to correct the abnormally low levels and bring them back into balance.

Estrogen is the primary sex hormone of the female. Prescription estrogen may be used if a woman has low estrogen levels due to premature failure of her ovaries. Estrogen is prescribed to bring these levels back into a normal range for the patient's age. Another labeled use of estrogen is to treat menopausal symptoms.

In GAT, what is termed "cross sex hormones" is the use of hormones of the opposite sex to attempt to create secondary sex characteristics. In order to do so, very high doses of these hormones are administered. When hormone levels climb above normal levels they are termed supraphysiologic.

The female person does produce some smaller amount of testosterone relative to the male. The normal reference range for adult females depending on the lab is about 10 to 50 ng/dL. However, in female disease conditions these levels can be much higher. For example, in polycystic ovarian syndrome levels may range from 50 to 150 ng/dL. PCOS has been associated with insulin resistance (Dunaif, 1989), metabolic syndrome (Apridonidze, 2005) and diabetes (Joham, 2014).

In certain endocrine tumors such as adrenal carcinoma these levels may be substantially higher in the 300 to 1000 ng/dl range. Adrenal carcinoma is a serious medical condition and may be treated by surgery and potent endocrine medications.

b. Opposite Sex Hormones - Supraphysiologic Doses of Testosterone for Females

Recommendations from the Endocrine Society's clinical guidelines are to ultimately raise female levels of testosterone to 320 to 1000 ng/dL⁶ which is on the same order as dangerous endocrine tumors for women as described above (Hembree, 2017). A simple calculation shows this level may be anywhere from 6 to 100 times higher than native female testosterone levels. In doing so they are creating a hormone imbalance known as hyperandrogenism. These extraordinarily high levels of testosterone are associated with multiple risks to the physical and mental health of the patient.

"Studies of transgender males taking testosterone have shown up to a nearly 5-fold increased risk of myocardial infarction relative to females not receiving testosterone" (Laidlaw et al., 2021; Alzahrani et al., 2019). A female can also develop unhealthy, high

⁶ In the Endocrine Society's Guidelines there is no grading of evidence for the rationale of using such high supraphysiologic doses of opposite sex hormones for the female or male. There seems to be an underlying assumption that because the person believes to be the opposite sex then they acquire the sex specific laboratory ranges of the opposite sex. "The root cause of this flaw in thinking about diagnostic ranges was exemplified in a response letter by Rosenthal et al claiming that gender identity determines the ideal physiologic range of cross-sex hormone levels (5). Thus a psychological construct, the "gender identity," is imagined to affect physical reality and change a person's sex-specific laboratory reference ranges. This is clearly not the case, otherwise there would be no serious complications of high-dose androgen treatment in transgender males" (Laidlaw et al., 2021).

levels of red blood cells referred to as erythrocytosis. These high red blood cell counts in young women have been shown to be an independent risk factor for cardiovascular disease, coronary heart disease and death due to both (Gagnon, 1994).

Other permanent effects of testosterone therapy involve irreversible changes to the vocal cords. Abnormal amounts of hair growth which may occur on the face, chest, abdomen, back and other areas is known as hirsutism. Should the female eventually regret her decision to take testosterone, this body hair can be very difficult to remove. Male pattern balding of the scalp may also occur. These changes of voice and hair growth can be very psychologically troubling when attempting to reintegrate into society as a female.

Changes to the genitourinary system include polycystic ovaries and atrophy of the lining of the uterus. The breasts have been shown to have an increase in fibrous breast tissue and a decrease in normal glandular tissue (Grynberg et al., 2010). Potential cancer risks from high dose testosterone include ovarian and breast cancer (Hembree, 2017).

According to research regarding testosterone abuse, high doses of testosterone have been shown to predispose individuals towards mood disorders, psychosis, and psychiatric disorders. The "most prominent psychiatric features associated with AAS [anabolic androgenic steroids, i.e. testosterone] abuse are manic-like presentations defined by irritability, aggressiveness, euphoria, grandiose beliefs, hyperactivity, and reckless or dangerous behavior. Other psychiatric presentations include the development of acute psychoses, exacerbation of tics and depression, and the development of acute confusional/delirious states" (Hall, 2005). Moreover, "[s]tudies... of medium steroid use (between 300 and 1000 mg/week of any AAS) and high use (more than 1000 mg/week of any AAS) have demonstrated that 23% of subjects using these doses of steroids met the DSM-III-R criteria for a major mood syndrome (mania, hypomania, and major depression) and that 3.4% — 12% developed psychotic symptoms" (Hall, 2005).

c. Opposite Sex Hormones - Supraphysiologic Estrogen for Males

For the male, estrogen is being used at supraphysiologic doses. The high doses are used in an attempt to primarily affect an increase of male breast tissue development known as gynecomastia. Gynecomastia is the abnormal growth of breast tissue in the male. The occurrence of gynecomastia in the male is sometimes corrected by medication or more commonly by surgery if needed. Other changes of secondary sex characteristics may develop such as softening of the skin and changes in fat deposition and muscle development.

The doses of estrogen given to males for GAT are high and may vary from two to eight or more times higher than normal adult male levels. This produces the endocrine condition called hyperestrogenemia. Long term consequences include increased risk of myocardial infarction and death due to cardiovascular disease (Irwig, 2018). Also "[t]here is strong evidence that estrogen therapy for trans women increases their risk for venous thromboembolism⁷ over 5 fold" (Irwig, 2018).

Breast cancer is a relatively uncommon problem of the male. However the risk of a male developing breast cancer has been shown to be 46 times higher with high dose estrogen (Christel et al., 2019).

It is clear that supraphysiologic doses of either testosterone for the female or estrogen for the male can have detrimental health consequences. This is only now being borne out in the literature for adults. However as more children and adolescents are put on these medications one would expect these consequences to become more frequent and to occur earlier in their lives.

7. Surgeries

The fourth stage of gender affirmative therapy is surgical alterations of the body of various kinds in an attempt to somehow mimic features of the opposite sex.

Individual surgical procedures can be a complex topic. It is helpful to first step back and consider conceptually what any surgery can and cannot accomplish.

In its basic form surgery is subtractive. In other words, a portion of tissue, an organ or organs are removed in order to restore health. For example, a diseased gallbladder may be surgically removed to help the patient get back to wellness. An infected appendix may be surgically removed to prevent worsening infection or even death. In both of these cases an unhealthy body part is surgically removed in order to restore health.

In some cases a diseased tissue or organ is removed so that a foreign replacement part may be substituted for an unhealthy organ or tissue. For example, a diseased heart valve may be replaced with a pig valve or a prosthetic heart valve. Another example is a failed liver may be replaced by liver transplant.

⁷ Venous thromboembolism is a blood clot that develops in a deep vein and "can cause serious illness, disability, and in some cases, death" (CDC, 2022).

Though modern surgical techniques and procedures are astounding, there are very noteworthy limitations. Importantly, surgery cannot de novo create new organs. If a person's kidneys fail, the surgeon has no scientific method for creating a new set of kidneys that can be implanted or grown within the patient. This conceptual background is helpful when considering various gender affirming surgeries.

There are a variety of gender affirming surgeries. These may include mastectomies, vaginoplasty, metoidioplasty, and phalloplasty.

a. Mastectomy

Mastectomies are the surgical removal of the breasts. The procedure is used in GAT in an attempt to make the chest appear more masculine. The surgery results in a permanent loss of the ability to breastfeed and significant scarring of 7 to 10 inches. The scars are prone to widening and thickening due to the stresses of breathing and arm movement. Other potential complications include the loss of normal nipple sensation and difficulties with wound healing.

It is important to note that this operation cannot be reversed. The female will never regain healthy breasts capable of producing milk to feed a child. Similar to the problems of receiving opposite sex hormones and puberty blockers at a young age, the adolescent is too young to consent to lifelong changes for which she cannot fully appreciate the ramifications. One would not generally expect a 13-year-old or 16-year-old to have thought deeply or to be concerned about breast-feeding in her 20s or 30s or older.

Another important consideration is that compared to the removal of an unhealthy gallbladder or appendix, in the case of gender dysphoria the breasts are perfectly healthy and there is no organic disease process such as a cancer warranting their removal. The future woman who later desists is left with regret about what happened to her at an age before she could provide true informed consent. Breasts cannot be created by a surgeon and restored to a patient in case of regret. She is left with permanent injury and loss of function with respect to her breasts.

Other types of surgery for females include those of the genitalia and reproductive tract. For example the ovaries, uterus, fallopian tubes, cervix and the vagina may be surgically removed. Removal of the ovaries results in sterilization.

Importantly, removing female body parts does not produce a male. Rather, the female has had sex specific organs permanently destroyed with no hope of replacement, while remaining biologically female.

There have also been attempts to create a pseudo-penis. This procedure is known as phalloplasty. It is not possible to de novo create a new human penis. Instead a roll of skin and subcutaneous tissue is removed from one area of the body, say the thigh or the forearm, and transplanted to the pelvis. An attempt is made to extend the urethra or urinary tract for urination through the structure. This transplanted tissue lacks the structures inherent in the male penis which allow for erection, therefore erectile devices such as rods or inflatable devices are placed within the tube of transplanted tissue in order to simulate erection (Hembree, 2017). The labia may also be expanded to create a simulated scrotum containing prosthetic objects to provide the appearance of testicles.

Complications may include urinary stricture, problems with blood supply to the transplanted roll of tissue, large scarring to the forearm or thigh, infections including peritonitis, and possible injury to the sensory nerve of the clitoris.

b. GAT Surgeries on the Male

GAT surgeries for the male include removal of the testicles alone to permanently lower testosterone levels. This is by nature a sterilizing procedure. Further surgeries may be done in an attempt to create a pseudo-vagina which is called vaginoplasty. In this procedure, the penis is surgically opened and the erectile tissue is removed. The skin is then closed and inverted into a newly created cavity in order to simulate a vagina. A dilator must be placed in the new cavity for some time so that it does not naturally close.

Potential surgical complications may include urethral strictures, infection, prolapse, fistulas and injury to the sensory nerves with partial or complete loss of erotic sensation.

c. The Effect of Puberty Blockers on the Vaginoplasty Procedure

It is important to understand that the use of puberty blockers for the male makes the vaginoplasty procedure even more complicated. Puberty blockers prevent the growth and elongation of the penis that naturally occurs during puberty. Therefore the surgeon has a limited length of penile skin to work with. In these cases a technique is employed whereby a segment of the large bowel (colon) is surgically excised while leaving its blood supply intact. The segment of colon is then connected to the short, inverted penile skin in attempt to extend the length of the pseudo-vagina. Obviously the risk and types

of complications increase further and multiple surgeries and revisions may need to be employed.

F. Life Threatening Physical Medical Conditions Versus Suicidal Ideation

Any child or adolescent who has suicidal ideation or has attempted suicide should receive immediate, appropriate psychiatric care. Psychologists and psychiatrists are trained in the recognition and treatment of suicidal ideation and prevention of suicide. A child or adolescent with gender dysphoria who also has suicidal ideation should not be treated any differently. They require compassionate care and a full psychological evaluation of comorbidities such as depression, anxiety, and self-harming behaviors.

However, suicidal ideation or attempts are categorically different than other life-threatening situations, such as a rapidly expanding brain tumor or a severe infection. In these situations, a medication or a surgery is used to stop the progression of an organic physical condition. In contrast, the danger to the self with suicidal ideation relates to a condition of the mind.

Gender affirmative therapy does not treat any life-threatening physical condition. In fact it creates a number of new medical conditions as described above. It is also not an appropriate treatment for suicidal ideation. Neither puberty blocking medications, nor testosterone, nor estrogen have been FDA approved for suicide prevention. In my opinion, it is possible that the hormone imbalances generated by the medications used in GAT may increase the risk of suicidal ideation and completed suicide.

G. Informed Consent

Any person who is to take a medication, undergo a surgical procedure, or have a psychological intervention should understand the risks and benefits before proceeding. A discussion of these risks and benefits should be provided by medical professionals and then the person of sufficient intellectual capacity and maturity can consent to the treatment.

Naturally difficulties arise when a minor is involved in the process of medical decision-making. Their intellect, emotions, and judgement are not fully developed and they are not capable of fully appreciating permanent, life altering changes such as described above. Therefore, they cannot provide informed consent. They may sometimes "assent" to a procedure or medication with a parent or guardian making the final decision.

With respect to GAT, I believe that it is not possible for the parent or guardian to make a true informed consent decision for the child because of the poor quality of evidence of benefit, the known risks of harm, and the many unknown long-term risks of harm which could only truly be known after years and decades of gender affirmative therapy. A parent or guardian cannot consent to dubious treatments which result in irreversible changes to their child's body, infertility, sexual dysfunction, and in many cases eventual sterilization.

Because this age group is still undergoing brain development and they are immature with respect to intellect, emotion, judgment, and self-control, in my professional opinion there is a significant chance a young person may later regret the irreversible bodily changes that result from hormones or from removing an organ or organs that will no longer function and cannot be replaced.

I would also note that adolescents are more prone to high-risk behavior and less likely to fathom the risks and consequences of these decisions (Steinberg, 2008).

H. The WPATH and The Endocrine Society

The declarations of Dr. Linda Hawkins, Dr. Stephen Rosenthal, and Dr. Jane Moe cite the World Professional Association for Transgender Health's ("WPATH") "Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People." According to their declarations, Dr. Hawkins is a longstanding member of WPATH, and Dr. Rosenthal is on the Board of Directors of WPATH.

WPATH's "Standards of Care" were prepared within their advocacy organization and are purported to be a "professional consensus about the psychiatric, psychological, medical, and surgical management of gender dysphoria" (WPATH, 2022). However, the "professional consensus" exists only within the confines of its organization. Furthermore, their "Standards of Care," unlike the Endocrine Society's guidelines, do not have a grading system for either the strength of their recommendations or the quality of the evidence presented.

While the Endocrine Society has issued "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," these are only "guidelines." The Endocrine Society's guidelines specifically state that their "guidelines cannot guarantee any specific outcome, nor do they establish a standard of care" (Hembree et al, 2017, p. 3895). This contradicts Dr. Rosenthal's claim about the guidelines calling it "a guide detailing the standard of medical care for gender dysphoria".

In the Endocrine Society's guidelines, the quality of evidence for the treatment of adolescents is rated "very low-quality evidence" and "low quality evidence". "The quality of evidence for [puberty blocking agents] is noted to be low. In fact, all of the evidence in the guidelines with regard to treating children/adolescents by [gender affirmative therapy] is low to very low because of the absence of proper studies" (Laidlaw et al., 2019).

Unlike some other recommendations for adolescent GAT, the Endocrine Society's guidelines do not include any grading of the quality of evidence specifically for their justification of laboratory ranges of testosterone or estrogen or for adolescent mastectomy or other surgeries.

I. The Lack of Evidence of Effectiveness of GAT

There is also evidence that questions the long-term effectiveness of opposite sex hormones and gender reassignment surgery. A Swedish study in 2011 examined data over a 30-year period (Dehejne, 2011). The Dhejne team made extensive use of numerous Swedish registries and examined data from 324 patients in Sweden over 30 years who had taken opposite sex hormones and had undergone sex reassignment surgery. They used population controls matched by birth year, birth sex, and reassigned sex. When followed out beyond ten years, the sex-reassigned group had nineteen times the rate of completed suicides and nearly three times the rate of all-cause mortality and inpatient psychiatric care compared to the general population of Sweden.

Other published studies of GAT have been shown to have serious errors. For example a major correction was issued by the American Journal of Psychiatry. The editors of an October 2019 study, titled "Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study" (Bränström study) retracted their original primary conclusion. Letters to the editor by twelve authors including myself led to a reanalysis of the data and a corrected conclusion stating that in fact the data showed no improvement in mental health for transgender identified individuals after surgical treatment ("Correction", 2020; Van Mol et al., 2020).⁸

The Centers for Medicare and Medicaid Services ("CMS") has found "inconclusive" clinical evidence regarding gender reassignment surgery. Specifically, the CMS Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-

⁸ The study also did not show an improvement in mental health with opposite sex hormones.

00446N) (June 19, 2019) states: “The Centers for Medicare & Medicaid Services (CMS) is not issuing a National Coverage Determination (NCD) at this time on gender reassignment surgery for Medicare beneficiaries with gender dysphoria because the clinical evidence is inconclusive for the Medicare population.”

Also noteworthy is that other nations are questioning gender affirmative therapy. For example in the Bell vs Tavistock Judgment in the UK, regarding puberty blockers in GAT, they concluded that “there is real uncertainty over the short and long-term consequences of the treatment with very limited evidence as to its efficacy, or indeed quite what it is seeking to achieve. This means it is, in our view, properly described as experimental treatment” (Bell v Tavistock Judgment, 2020).

Finland in 2020 recognized that “[r]esearch data on the treatment of dysphoria due to gender identity conflicts in minors is limited,” and recommended prioritizing psychotherapy for gender dysphoria and mental health comorbidities over medical gender affirmation (Council for Choices in Healthcare in Finland, 2020).

In 2021, Sweden’s largest adolescent gender clinic announced that it would no longer prescribe puberty blockers or cross-sex hormones to youth under 18 years outside clinical trials (SEGM, 2021).

Dr Hilary Cass “was appointed by NHS England and NHS Improvement to chair the Independent Review of Gender Identity Services for children and young people in late 2020” (The Cass Review website, 2022).

In her interim report dated February 2022, it states that “[e]vidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally” (Cass, 2022).

Conclusion

The gender affirmative therapy model suffers from serious deficiencies in logic and lacks scientific foundation. The deep error hidden in this model is that one cannot in fact change sex. One cannot acquire the deep characteristics of biological sex in order to gain the complete sexual and reproductive functions of the opposite sex. This is not technologically possible.

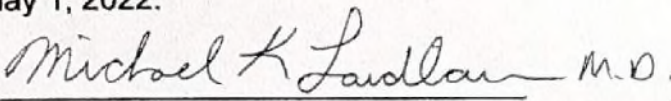
Children and adolescents are of such immature minds that they are likely to believe that it is possible. In fact they may come to believe that their inherent, biologically necessary puberty is “terrifying”. This fear begins as the result of social transition. Puberty blockers

sustain this state of mind by retaining a childlike state with respect to the genitalia and body habitus. High dose opposite sex hormones then cause medical conditions such as gynecomastia and hirsutism. These conditions serve to convince the young person that they are going through puberty of the opposite sex when in fact they are not developing sexually and are infertile.

There are known risks, some of which I have described above, including cardiovascular disease, cancer, deficiencies in ultimate bone density, harms to sexual function, infertility, and for some permanent sterility. The child or adolescent cannot consent to these harms when they are not mature enough to fully comprehend what they mean.

For the reasons set forth above, in my professional opinion as an endocrinologist, no child or adolescent should receive puberty blockers to block normal puberty, nor should they receive supraphysiologic doses of opposite sex hormones to attempt to alter secondary sex characteristics, nor should they have surgeries to remove or alter the breasts, genitalia or reproductive tracts as part of GAT. The child cannot consent or assent to these procedures. The parent or guardian also cannot consent to the life altering changes resulting from GAT. Therefore I believe that the Alabama Vulnerable Child Compassion and Protection Act is based on sound medical principles for the protection of minors.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed on May 1, 2022.


Michael K. Laidlaw

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EMPLOYMENT

2006-Present Michael K Laidlaw, MD Inc. Private Practice – Endocrinology, Diabetes, and Metabolism. Rocklin, CA

EDUCATION

2004-2006 Endocrinology and Metabolism Fellowship - Los Angeles County/University of Southern California Keck School of Medicine
2001-2004 Internal Medicine Residency - Los Angeles County/University of Southern California Keck School of Medicine
1997-2001 University of Southern California Keck School of Medicine
Doctor of Medicine Degree May 2001
1990-1997 San Jose State University
Bachelor of Science Degree in Biology with a concentration in Molecular Biology, Cum Laude

LICENSURE

California Medical License – Physician and Surgeon: # A81060: Nov 6, 2002. Exp 5/31/2024.

PROFESSIONAL AFFILIATIONS

Endocrine Society 2006-2022
National Board of Physicians and Surgeons - Endocrinology, Diabetes, & Metabolism 2018-2024
National Board of Physicians and Surgeons - Internal Medicine 2018-2024
American Board of Internal Medicine - Endocrinology, Diabetes, and Metabolism – 2006-2016
American Board of Internal Medicine - Internal Medicine - 2005-2015

HONORS AND RECOGNITION

2010 Endocrine Society Harold Vigersky Practicing Physician Travel Award
2004-2005 Vice President - Joint Council of Interns and Residents
2002-2004 Council Member – Joint Council of Interns and Residents
1996, 1997 Dean's Scholar, San Jose State University
1995 Golden Key National Honor Society

RESEARCH, PUBLICATIONS, AND EXPERT REPORTS

- 2021 Publication – Michael K Laidlaw, Andre Van Mol, Quentin Van Meter, Jeffrey E Hansen. Letter to the Editor from M Laidlaw et al.: “Erythrocytosis in a Large Cohort of Trans Men Using Testosterone: A Long-Term Follow-Up Study on Prevalence, Determinants, and Exposure Years.” The Journal of Clinical Endocrinology & Metabolism, Volume 106, Issue 12, December 2021, Pages e5275–e5276, <https://doi.org/10.1210/clinem/dgab514>
- 2021 Brief of Amicus Curiae – Bursch, John J., McCaleb, Gary S., Van Meter, Quentin L., Laidlaw, Michael K., Van Mol, Andre, Hansen, Jeffrey E. Brief of Amicus Curiae. United States Court of Appeals for the Eight Circuit. DYLAN BRANDT, et al., Plaintiffs-Appellees v. LESLIE RUTLEDGE, in her official capacity as the Arkansas Attorney General, et. al. Defendants-Appellants. 23 Nov 2021.
- 2020 Expert Witness Affidavit 1 & 2 – Laidlaw MK. Supreme Court of British Columbia. File No. S2011599, Vancouver Registry. Between A.M. Plaintiff and Dr. F and Daniel McKee Defendants. 11/23/20 & 11/25/20.
- 2020 Brief of Amicus Curiae – Wenger, Randal L., McCaleb, Gary S., Grossman, Miriam, Laidlaw, Michael K., McCaleb, Gary S., Van Meter, Quentin L., Van Mol, Andre. Brief of Amicus Curiae. United States Court of Appeals for the Ninth Circuit. LINDSAY HECOX and JANE DOE, with her next friends Jean Doe and John Doe, Plaintiffs-Appellees v. BRADLEY LITTLE, in his official capacity as Governor of the State of Idaho, et. al. Defendant-Appellant. 19 Nov 2020
- 2020 Expert Declaration – Laidlaw MK. United States District Court for the District of Arizona. DH and John Doe, Plaintiffs, vs. Jami Snyder, Director of the Arizona Health Care Cost Containment System, in her official capacity, Defendant. Case No. 4:20-cv-00335-SHR. 27 Sep 2020.
- 2020 Publication – Van Mol A, Laidlaw MK, Grossman M, McHugh P. "Correction: Transgender Surgery Provides No Mental Health Benefit." Public Discourse, 13 Sep 2020. <https://www.thepublicdiscourse.com/2020/09/71296/>
- 2020 Publication – VanMol A, Laidlaw MK, Grossman M, McHugh P.. "Gender-affirmation surgery conclusion lacks evidence (letter)". Am J Psychiatry 2020; 177:765–766.
- 2020 Publication – Laidlaw MK. "The Pediatric Endocrine Society’s Statement on Puberty Blockers Isn’t Just Deceptive. It’s Dangerous." Public Discourse. 13 Jan 2020. <https://www.thepublicdiscourse.com/2020/01/59422/>
- 2019 Expert Witness Affidavit – Laidlaw MK. Court of Appeal File No. CA45940, Vancouver Registry. B.C. Supreme Court File No. E190334, between A.B. Respondent/Claimant, and C.D. Appellant/Respondent, and E.F. Respondent/Respondent. 24 Jun 2019.
- 2019 Speech to the U.K. House of Lords – Laidlaw MK. “Medical Harms Associated with the Hormonal and Surgical Therapy of Child and Adolescent Gender Dysphoria”. Parliament, London, U.K. 15 May 2019.
- 2019 Publication – Laidlaw MK, Cretella M, Donovan K. "The Right to Best Care for Children Does Not Include the Right to Medical Transition". The American Journal of Bioethics. Volume 19. Published online 20 Feb 2019. 75-77. <https://doi.org/10.1080/15265161.2018.1557288>
- 2018 Brief of Amicus Curiae – Alliance Defending Freedom, Campbell, James A., Grossman, Miriam, Laidlaw, Michael K., McCaleb, Gary S., Van Meter, Quentin

L., Van Mol, Andre. Brief of Amicus Curiae. United States Court of Appeals for the Eleventh Circuit. Drew Adams, Plaintiff-Appellee, v. School Board of St. Johns County, Florida, Defendant-Appellant. 12/27/2018.

- 2018 Publication – Laidlaw MK, Van Meter QL, Hruz PW, Van Mol A, Malone WJ. Letter to the Editor: “Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline.” The Journal of Clinical Endocrinology & Metabolism, Volume 104, Issue 3, 1 March 2019, Pages 686–687, <https://doi.org/10.1210/jc.2018-01925> (first published on-line 11/2018)
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- 2018 Publication – Laidlaw MK. “Gender Dysphoria and Children: An Endocrinologist’s Evaluation of ‘I am Jazz’”. Public Discourse, 5 Apr 2018. <https://www.thepublicdiscourse.com/2018/04/21220/>
- 2013 Abstract – Poster presentation Jun 2013. Endocrine Society Annual Meeting. A 12 Step Program for the Treatment of Type 2 Diabetes and Obesity.
- 2011 Abstract – Poster presentation Nov 2011. Journal of Diabetes Science and Technology. A Video Game Teaching Tool for the Prevention of Type 2 Diabetes and Obesity in Children and Young Adults.
- 2011 Abstract – Journal of Diabetes Science and Technology. A Web-Based Clinical Software Tool to Assist in Meeting Diabetes Guidelines and Documenting Patient Encounters.
- 2008 Abstract - Accepted to Endocrine Society Annual Meeting 2008. Hypercalcemia with an elevated 1,25 dihydroxy-Vitamin D level and low PTH due to granulomatous disease.
- 2005-2006 Clinical Research - University of Southern California – Utility of Thyroid Ultrasound in the Detection of Thyroid Cancer. Study involving the use of color flow/power doppler ultrasound and ultrasound guided biopsy to detect the recurrence of thyroid cancer in patients with total thyroidectomies.
- 2005 Certification - Certification in Diagnostic Thyroid Ultrasound and Biopsy – AACE 2005
- 2003 Certification - Understanding the Fundamentals: Responsibilities and Requirements for the Protection of Human Subjects in Research. University of Southern California. 29 Sep 2003 - 29 Sep 2006
- 2002-2005 Clinical Research - University of Southern California - Determining the Role of Magnesium in Osteoporosis. Study involved collecting and analyzing patient data related to patient characteristics, laboratory results, bone mineral density exams, nutrition analysis, and genetic analysis in order to determine a link between magnesium deficiency and osteoporosis.
- 1996 Research Assistant - San Jose State University - Role of the suprachiasmatic nucleus pacemaker in antelope ground squirrels.
- 1995-1996 Research Assistant - San Jose State University/NASA. Acoustic tolerance test and paste diet study for space shuttle rats.

PERSONAL

Languages: Conversational Spanish, French

Tutor: Biochemistry, computer science, High School mentor

Computers: Ruby, Rails, Javascript, C++, C, Java, and HTML programming

DOC. 69-4

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER,	)	
<i>et al.</i> ,	)	
	)	
<i>Plaintiffs</i> ,	)	
	)	
v.	)	No. 2:22-cv-00184-LCB-SRW
	)	
KAY IVEY, in her official capacity	)	
as Governor of the State of Alabama,	)	
<i>et al.</i> ,	)	
	)	
<i>Defendants.</i>	)	

DECLARATION OF QUENTIN L. VAN METER, M.D.

My name is Quentin L. Van Meter. I am over the age of 19, I am qualified to give this declaration, and I have personal knowledge of the matters set forth herein.

My CV is attached to this declaration. My recent publications in the *Journal of Clinical Endocrinology and Metabolism* are listed on my CV.

In the past four years, I have provided expert testimony in state legislative committee hearings in Alabama, Pennsylvania, Missouri, Iowa, and California, and I have been deposed as an expert witness in Virginia, Ohio, Missouri, and Georgia:

- 2018: Court of the Queens Bench Ontario, court file 1808-00144, deposed
- 2018: Sieffert v Hamilton Co Ohio, court testimony
- 2019: Gavin Grimm v Gloucester Co Virginia School Board, deposed
- 2019: Multiple Plaintiffs v State of Ohio Bureau of Records, deposed
- 2020: Loughman v Loughman, Harris County, Texas, deposed
- 2021: Spahr v Spahr, St Louis County, MO, court testimony
- 2021: Laura Cauthen v James Cauthen, Cobb County GA, court testimony

I am compensated at the rate of \$350.00 per hour for record review and document preparation and \$450.00 per hour for deposition or court testimony on this matter. My compensation is not dependent upon the substance of my opinions or the outcome of the case.

Qualifications

I have been retained by counsel for Defendants as an expert in connection with the above-captioned litigation. I have actual knowledge of the matters stated in this declaration. My professional background, experience, and publications are detailed in my curriculum vitae. A true and accurate copy is attached as Exhibit A to this declaration. I received my B.A. in Science at the College of William and Mary and my M.D. from the Medical College of Virginia, Virginia Commonwealth University. I am currently a pediatric endocrinologist in private practice in Atlanta, Georgia. I am the President of Van Meter Pediatric Endocrinology, P.C. I am on the clinical faculties of Emory University School of Medicine and Morehouse College of Medicine, in the role of adjunct Associate Professor of Pediatrics. I am board certified in Pediatrics and Pediatric Endocrinology. I have been licensed to practice medicine in Georgia since 1991. I have been previously licensed to practice medicine in California, Louisiana, and Maryland.

I did my Pediatric Endocrine fellowship at Johns Hopkins Hospital from 1978-1980. The faculty present at that time had carried on the tradition of excellence established by Lawson Wilkins, M.D. Because of the reputation of the endocrine program as a center for exceptional care for children with disorders of sexual differentiation, I had well-above average exposure to such patients. As a Pediatric Fellow, I was also exposed to adults with Gender Identity Disorder, then called Trans-Sexuality, and received training from John Money, Ph.D., in his Psychohormonal Division.

Differentiation in the Fetus

From the moment of conception, a fetus is determined to be either a male (XY), female (XX), or in rare cases, to have a combination of sex-determining chromosomes, many of which are not compatible with life, and some of which are the cause of identifiable clinical syndromes.

The presence of a Y chromosome in the developing fetus directs the developing gonadal tissue to develop as a testicle. The absence of a functional Y chromosome allows the gonadal tissue to develop as an ovary. Under the influence of the mother's placental hormones, the testicle will produce testosterone which directs the genital tissue to form a penis and a scrotum.

Simultaneously, the testicle produces anti-Müllerian Hormone (AMH) which regresses development of the tissue that would otherwise develop into the uterus, fallopian tubes, and upper third of the vagina. This combination of actions in early fetal development is responsible for what we subsequently see on fetal sonograms, and what we observe at birth as male or female genitalia. It is only when the genital structures are ambiguous in appearance that sex assignment is withheld until a thorough expert team evaluation has occurred.

For reasons most often occurring as random events, there are malfunctions of the normal differentiation. These aberrations of normal development are responsible for what we classify as Disorders of Sexual Differentiation (DSD), and they represent a very small fraction of the human population. The incidence of such circumstances occurs in 1:4500 to 1:5500 births.¹ Sex is binary, male or female, and is determined by chromosomal complement and corresponding reproductive role. The exceedingly rare DSDs are all medically identifiable deviations from this sexual binary norm. The 2006 consensus statement of the Intersex Society of North America and the 2015 revision of the Statement do not endorse DSD as a third sex.² DSD outcomes range from appearance of female external genitalia in an XY male (complete androgen insensitivity syndrome) to appearance of male external genitalia in an XX female (severe congenital adrenal hyperplasia).

As one would expect, there are variations of the degree of hormonally driven changes that create ambiguous genital development that prevent assigning of a specific classification as

either male or female at birth. DSD patients are not “transgender”; they have an objective, physical, medically verifiable, physiologic condition. Transgender people generally do not have intersex conditions or any other verifiable physical anomaly. People who identify as “feeling like the opposite sex” or “somewhere in between” do not comprise a third sex. They remain biological men or biological women.

In some DSDs there exist more than one set of chromosomes. When there is a divergence of the appearance of the external genitalia from the chromosomally determined sex due to the presence of both an ovarian and testicular cell lines in a patient simultaneously, the patient is classified as having ovo-testicular DSD (formerly termed a true hermaphrodite). When there is a disruption in the development of genital structures but there is solely testicular tissue present in the chromosomal male or solely ovarian tissue in the chromosomal female, the term 46 XY DSD or 46 XX DSD is used instead respectively (formerly termed male pseudohermaphrodite or female pseudohermaphrodite).

The decision to assign a sex of rearing is complex and is specific to the diagnosis. Patients with complete androgen insensitivity (CAIS) are XY DSD but are never reared as a male. Because testosterone never influences development, they become happy, functional female adults with infertility. Females with severe congenital adrenal hyperplasia (CAH) are XX DSD but are not reared as males despite the male appearance of the genitalia at birth. Although these girls may show a tendency for male play behaviors as children, they generally assume a female sexual identity. Therapeutic interventions in the DSD individuals from infancy onward are aimed at what function can be expected from their disordered sexual anatomy in terms of function and fertility. Most often, the chromosomal sex aligns with the sex of rearing.

Gender Identity

“Gender” is a term that refers to the psychological and cultural characteristics associated with biological sex. It is a psychological concept and sociological term, not a biological one. The term gender possessed solely a linguistic meaning prior to the 1950s. This changed when sexologists of the 1950s and 1960s co-opted the term to conceptualize cross-dressing and transsexualism in their psychological practice. “Gender identity” is a term coined by my former endocrine faculty member John Money in the 1970s and has come to refer to an individual’s mental and emotional sense of being male or female. The norm is for individuals to have a gender identity that aligns with one’s biological sex.

Gender discordance (formerly Gender Identity Disorder) is used to describe a psychological condition in which a person experiences marked incongruence between his experienced gender and the gender associated with his biological sex. He will often express the belief that he is the opposite sex. Gender discordance occurs in 0.001% of biological females and in 0.0033% of biological males.³ Exact numbers are hard to document since reporting is often anecdotal. Gender discordance is not considered a normal developmental variation.

“Gender Dysphoria” is a diagnostic term to describe the emotional distress caused by gender incongruity.⁴ John Money played a prominent role in the early development of gender theory and transgenderism. He understood gender to be “the social performance indicative of an internal sexed identity.”⁵ He joined the Johns Hopkins faculty in 1951 specifically to have access to children diagnosed with DSD, hoping to prove his theory that gender was arbitrary and fluid. Money experimented with DSD infants by assigning them to the opposite biological sex through surgical revision, counseling, and hormonal manipulation during puberty. His mode of operation was to have a theory and then experiment with patients to see how his theory worked. This kind

of endeavor does not anticipate or prevent adverse outcomes and is the antithesis of ethical science. Money never submitted his research proposals for review; today, Institutional Review Boards (IRBs) serve to rigorously review proposed clinical research protocols to prevent all potential and real harm to patients.

Because of his experience with infants, Money initially garnered support from endocrine colleagues and surgical colleagues, and Johns Hopkins became a renowned center for care of patients with DSD in the 1970s, garnering referrals from around the world. Follow-up studies on these infants later showed, however, that altering their natal sexual identity via social intervention could lead to severe psychological harm. Clinical case reports of children with DSD have revealed that gender identity is indeed not immune to environmental input.⁶

Meanwhile, Money had expanded into the field of adult patients with persistent gender identity disorder. This very small group of patients chose voluntarily, as adults, to enter a very precise protocol which began with living socially as the opposite sex for a year, eventually receiving hormonal therapy to change their physical appearance to some extent. The final step was surgical revision of the body structures that would otherwise be at odds with their desired gender. This small group of patients was followed for a number of years past their final surgical procedures and required continuous counseling. These patients expressed some degree of subjective satisfaction but showed no objective improvement in overall wellbeing.⁷ The legacy of John Money fell into disrepute and the transsexual treatment program at Johns Hopkin was closed in the 1980s based on the lack of evidence that this protocol produced an effective cure.

Etiology of Gender Disorders

Transgender affirming professionals claim transgender individuals have a "feminized brain" trapped in a male body at birth and vice versa based upon various brain studies. Diffusion-

weighted MRI scans have demonstrated that the pubertal testosterone surge in boys increases white matter volume. A study by Rametti and colleagues found that the white matter microstructure of the brains of female-to-male (FtM) transsexual adults, who had not begun testosterone treatment, more closely resembled that of men than that of women.⁸ Other diffusion-weighted MRI studies have concluded that the white matter microstructure in both FtM and male-to-female (MtF) transsexuals falls halfway between that of genetic females and males.⁹ These studies, however, are of limited clinical significance due to the small number of subjects and failure to account for neuroplasticity.

Neuroplasticity is the well-established phenomenon in which long-term behavior alters brain microstructure. For example, the MRI scans of experienced cab drivers in London are distinctly different from those of non-cab drivers, and the changes noted are dependent on the years of experience.¹⁰ There is no evidence that people are born with brain microstructures that are forever unalterable, but there is significant evidence that experience changes brain microstructure.^{11,12} Therefore, any transgender brain differences would more likely be the result of transgender behavior than its cause.

Furthermore, infants' brains are imprinted prenatally by their own endogenous sex hormones, which are secreted from their gonads beginning at approximately eight weeks' gestation.^{13,14,15} There are no published studies documenting MRI-verified differences in the brains of gender-disordered children or adolescents. The DSD guidelines also specifically state that current MRI technology cannot be used to identify those patients who should be raised as males or raised as females.¹⁶ Behavior geneticists have known for decades that while genes and hormones influence behavior, they do not hard-wire a person to think, feel, or behave in a particular way. The science of epigenetics has established that genes are not analogous to rigid

“blueprints” for behavior. Rather, humans “develop traits through the dynamic process of gene-environment interaction. ... [genes alone] don't determine who we are.”¹⁷

Regarding transgenderism, twin studies of adults prove definitively that prenatal genetic and hormone influence is minimal. The largest twin study of transgender adults found that only 20 percent of identical twins were both transgender-identified.¹⁸ Since identical twins contain 100 percent of the same DNA from conception and develop in exactly the same prenatal environment exposed to the same prenatal hormones, if genes and/or prenatal hormones contributed to a significant degree to transgenderism, the concordance rates would be close to 100 percent. Instead, 80 percent of identical twin pairs were discordant. This difference would indicate that at least 80 percent of what contributes to transgenderism as an adult in one co-twin consists of one or more non-shared post-natal experiences including but not limited to non-shared family experiences. These findings also mean that persistent GD is due predominately to the impact of nonshared environmental influences. These studies provide compelling evidence that discordant gender is not hard-wired genetically.

Gender Dysphoria vs. Gender Identity Disorder

Up until the recent revision of the DMS-IV criteria, the American Psychological Association (APA) held that Gender Identity Disorder (GID) was the mental disorder described as a discordance between the natal sex and the gender identity of the patient. Dr. Kenneth Zucker, who is a highly respected clinician and researcher from Toronto, carried on evaluation and treatment of GID patients for forty years. His works, widely published, found that the vast majority of boys and girls with GID identify with their biological sex by the time they emerge from puberty to adulthood, through either watchful waiting or family and individual counseling.¹⁹ His results were mirrored in studies from Europe.^{20,21}

When the DMS-V revision of the diagnosis of GID was proposed by the APA committee responsible for revision, Dr. Zucker strongly opposed the change to the term Gender Dysphoria, which purposefully removed gender discordance as a mental disorder apart from the presence of significant emotional distress. With this revision, Gender Dysphoria describes the mental anguish which is experienced by the gender discordant patient. The theory that societal rejection is the root cause of Gender Dysphoria was validly questioned by a study from Sweden which showed that the dysphoria was not eliminated by hormones and sex reassignment surgery even with widespread societal acceptance.²²

Treatment of Gender Dysphoria

The treatment of children and adolescents with gender discordance and accompanying gender dysphoria should include an in-depth evaluation of the child and family dynamics. This evaluation provides a basis on which to proceed with psychologic therapy. The entire biologic and social family should be involved in psychological therapy designed to assist the patient, if at all possible, to align gender identity with natal sex. Psychological support by competent counselors with an intent of resolving the gender conflict should be provided as long as the patient continues to suffer emotionally. Given the high degree of eventual desistance of gender discordance/dysphoria by the end of puberty, it would be ethical and logical to counsel the patient and family to rear the child in conformity with natal sex.

There should be no interruption of natural puberty. Natural pubertal maturation in accordance with one's natal sex is not a disease. It is designed to carry malleable, immature children forward to be healthy adults capable of conceiving their own progeny. Puberty affects physical changes, some of them painful, unique to the natal sex to reflect the laws of nature. Interruption of puberty has been reserved for children who begin puberty at an age much

younger than normal in an effort to preserve final height potential and avoid the social consequences of precocious maturation.

There are a number of physical changes that are a consequence of normally timed puberty that could be classified as disadvantageous: changes in body proportions can alter success with dance and gymnastics; acne can be severe and disfiguring; a boy soprano can suddenly hardly carry a tune. It has not been the ethical standard of care to stop puberty so that these changes can be circumvented. Erikson described the stage of adolescence as "Identity versus Role Confusion" during which the teen works at developing a sense of self by testing roles then integrating them into a single identity.²³ This process is often unpleasant regardless of the presence or absence of gender identity conflicts. The major benefit of enduring puberty in a GD patient is that it provides a strong likelihood of alignment of his gender identity with his natal sex. There is no doubt that these patients need compassionate care to get them through their innate pubertal changes.

The light at the end of the tunnel is the proven scientific evidence that 80%- 95% of pre-pubertal children with GD will come to identify with their biological sex by late adolescence. Some will require lifelong supportive counseling while others will not.²⁴ Intervention at a young age with gonadotropin releasing hormone analogs (often referred to as puberty blockers) to either stop puberty early on or prevent it from starting before it naturally occurs is suggested by guidelines developed by WPATH without scientific basis. There is evidence that bone mineral density is irreversibly decreased if puberty blockers are used during the years of adolescence.²⁵ To treat puberty as a pathologic state of health that should be avoided by using puberty blockers (GnRH analogs) is to interrupt a major necessary physiologic transformation at a critical age when such changes can effectively happen. We have definite evidence of the need for estrogen in

females to store calcium in their skeleton in their teen years. That physiologic event can't be put off successfully to a later date. It is very difficult to imagine ethical controlled clinical trials that could elucidate the effects of delaying puberty until the age of consent.

The use of cross-sex hormones during this same time frame has no basis of safety and efficacy. The use of such treatment in adults raises scientifically valid concerns that were amply expressed in the 2009 Endocrine Society Guidelines on Transgender treatment. The next step in WPATH-recommended intervention is to use cross-sex hormone therapy during the time when the patient would naturally be experiencing endogenous pubertal changes. This too is not based on scientifically proven theories. The use of cross-sex hormones can cause permanent infertility.²⁶

The final recommended step is so-called "sex reassignment surgery," which can include surgical removal of the breasts in natal females, or removal of the penis and scrotum in natal males. Each of these steps has adverse outcomes, some reversible and others not. Mastectomies leave scars, and there is great difficulty in creating a functional vaginal-like orifice, and certainly no success in creating an innervated erectile penis where none existed previously. Sex reassignment surgery is, by nature, permanent.

Recurrent Themes in the Plaintiff Declarations

Puberty blockers are stated to be completely reversible in their effects on the adolescent who has entered puberty based on clinical studies in young children with precocious puberty who have been treated with these drugs. This is comparing apples to oranges. Precocious puberty, by definition, is defined as puberty which starts before the 8th birthday for a female child or the before the 9th birthday in a male child. The end of treatment is carefully timed so that resumption of puberty occurs at the average age for females (10.5 years) and males (11.5 years). This allows

the necessary functions of puberty to prepare the body for reproduction and affects the bones, gonads, and brain, among other body systems. On the other hand, blocking puberty at the age of normal puberty prevents the needed accretion of calcium into the skeleton and prevents the maturation of the gonads. There is no long-term data that compares bone, gonad, and brain health in pubertal-aged patients who have had puberty interrupted and those who have not, as was noted as a concern in the Endocrine Society Guidelines. There are no such ongoing studies completed that guarantee the full reversibility of blocking puberty in this age group, but there is evidence that normal bone density can't be fully reestablished. Without any verifiable safety data, using the puberty blockers for interrupting normal puberty is not a sanctionable off-label use of these drugs and is therefore to be considered uncontrolled, non-consentable experimentation on children.

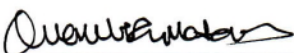
It has been stated that the plaintiffs are only asking that established standards of care be followed. There are no standards of care for transgender health. Standards of care established by broad consensus are reached by inclusion of the whole spectrum of opinions, clinical experience and published science in the formation thereof. The guidelines published by WPATH,²⁷ the Endocrine Society,^{26,28} the American Academy of Pediatrics,²⁹ and the Pediatric Endocrine Society³⁰ are solely the opinions of like-minded practitioners who excluded any contrary opinion. The Endocrine Society Guidelines, as mentioned before, clearly stated that they are not to be considered standards of care. Before true consensus-driven standards of care are established for the treatment of transgender patients of all ages, following the current guidelines is risky experimentation.

The plaintiff declarations repeatedly refer to the established increased risk of suicide if any of the affirmation strategies are not followed to completion. There are only two total

population studies in the peer-reviewed medical literature.^{22,31,32} They show that when every recorded case in the population of Sweden was analyzed, neither medical affirmation or medical affirmation followed by surgical affirmation improved the mental health of the patients in the long run.

Finally, I am curious about the clear lack of documentation of references in the plaintiffs' declarations. They are merely stating their personal opinions without supporting evidence and relying on anecdotal case reports.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed on 1 May, 2022.



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Home Address: [REDACTED], Atlanta, GA 30309
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Date of Birth: September 13, 1947
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Citizenship: USA

EDUCATION:

Undergraduate: College of William & Mary, 1969
B.S. – 1969
Medical School: Medical College of Virginia, 1973
M.D. – 1973

CLINICAL TRAINING:

Institution: The University of California, San Francisco
Hospital: Naval Regional Medical Center, Oakland
Position: Pediatric Intern – 1973 – 1974
Pediatric Resident – 1974 – 1976

Institution: Johns Hopkins University
Hospital: Johns Hopkins Hospital
Position: Fellow, Pediatric Endocrinology 1978 – 1980
Fellowship Program Director: Claude Migeon, M.D.

Current Position: Pediatric Endocrinologist
Van Meter Pediatric Endocrinology, P.C.
1800 Howell Mill Road, Suite 475
Atlanta, Georgia 30318

PROFESSIONAL CERTIFICATION & SOCIETIES:

Diplomate, National Board of Medical Examiners, 1974

American Board of Pediatrics, certified in general pediatrics, 1978, sub-board certified
in Pediatric Endocrinology, 1983

Fellow: American Academy of Pediatrics, Georgia Chapter 1975 -present
President, Uniformed Services West Chapter, 1987 – 1990
District VIII member, AAP Committee on Awards for
Excellence in Research, 1990-1994
Editor, The Georgia Pediatrician, 1994 – 1998

Chairman, Georgia Chapter Legislative Committee, 1996 – 2006

Fellow: The American College of Pediatricians, 2007 – present
Member of the Board of Directors, 2008- present
President, 2018-present

Member: Pediatric Endocrine Society, 1989 – present

Member: American Diabetes Association Professional Section, 1988 – present

Member: Endocrine Society, 1994-present

Member: Southern Pediatric Endocrine Society, 1992 – Present

Member: American Association of Clinical Endocrinologists, 2005 – present

Licensure: Georgia, #34734

FACULTY POSITIONS:

Institution: Morehouse School of Medicine
Position: Associate Clinical Professor, Pediatrics, 2004 – present

Institution: Emory University School of Medicine
Position: Adjunct Associate Professor, Pediatrics, 1991 – present

Institution: University of California, San Francisco
Position: Associate Clinical Professor, Pediatrics, 1989 – 1991

Institution: University of California, San Diego, School of Medicine
Position: Assistant Clinical Professor, Pediatrics, 1980 – 1986

Institution: LSU School of Medicine, Clinical Instructor, Pediatrics, 1977 – 1978

MILITARY SERVICE:

Commission: Medical Corps, United States Navy, August 1971
Rank: Captain, retired
Duty Stations: Health Professional Scholarship Student, 1971 – 1974

Intern and Resident, Pediatrics, Naval Regional Medical Center,
Oakland, 1973 – 1976

Staff Pediatrician, Naval Regional Medical Center,
Oakland, 1976

Staff Pediatrician, Naval Regional Medical Center,
New Orleans, 1976 – 1978

Full time out-service fellow in Pediatric Endocrinology,
Johns Hopkins Hospital, 1978 – 1980

Staff Pediatric Endocrinologist, Naval Hospital San Diego,
1980 – 1986

Chairman and Director, Residency Training, Department of Pediatrics
Naval Hospital Oakland, 1986 – 1991

OTHER PROFESSIONAL ACTIVITIES:

Consultant, Pediatric Endocrinology,
Nellis Air Force Base Hospital, Las Vegas, Nevada
1981 – 1991

Consultant, Pediatric Endocrinology,
Naval Hospital Lemoore, CA
1986 – 1991

Consultant, Pediatric Endocrinology,
Letterman Army Medical Center, Presidio of San Francisco, CA
1990 – 1991

Consulting Endocrinologist,
Columbus Regional Medical Center, Columbus, GA
1991 – 1994

Pediatrician and Pediatric Endocrinologist, partner
Fayette Medical Clinic
Peachtree City, Georgia 30269
September 1991 – October 2003

Pediatric Endocrinologist Peer Reviewer 2006 – present
MCMC, LLC, Boston, MA
IMEDECS, Lansdale PA

Speaker's Bureau
Novo Nordisk
AAP Eqipp course on Growth- development committee- 2012

PUBLICATIONS: (Articles in Peer Reviewed Journals)

Riddick, JR, Flora R., Van Meter, QL:

“Computerized Preparation of Two-Way Analysis of Variance Control Charts for Clinical Chemistry,” Clinical Chemistry, 18:250, March 1972.

Van Meter, QL, Gareis FJ, Hayes, JW, Wilson, CB:

“Galactorrhea in a 12 Year Old Boy with Chromophobe Adenoma,” J. Pediatrics 90:756, May 1977.

Plotnick, LP, Van Meter, QL, Kowarski, AA, “Human Growth Hormone Treatment of Children with Growth Failure and Normal Growth Hormone Levels by Immunoassay: Lack of Correlation with Somatomedin Generation: Pediatrics 71:324, March 1983.

Brawley, RW, Van Meter, QL, “Mebendazole Ascaris Migration,” W.J. Med, 145:514015, October 1986.

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ABSTRACTS/LETTERS:

Van Meter, Q L, & Lee, PA: “Evaluation of Puberty in Male and Female Patients with Noonan Syndrome,” Pediatric Research 14:485, 1980.

Van Meter, QL, et al: "Characterization of Pituitary Function in Double Bolus GnRH Infusion as a Diagnostic Tool," Pediatric Research 32:111, 1984.

Van Meter, QL, Felix, SD, Lin, FL: "Evaluation of the Pituitary-Adrenal Axis in Patients Treated with nasal Beclomethasone," (Presented at the 1991 Annual Meeting of the Endocrine Society and the 6th Annual Naval Academic Research Competition, Bethesda, MD, 17 May, 1991).

Rogol AD Midyett LK Van Meter Q, Frane J, Baily J, and Bright GM, Recombinant Human IGF-1 for Children with Primary IGF-1 Deficiency (IGFD): Safety Data from Ongoing Clinical Trials (presented at the PAS 2007, Toronto).

Van Meter Q, Midyett LK, Deeb L et al, Prevalence of primary IGFD among untreated children with short stature in a prospective, multicenter study (Poster POO715) ICE Rio de Janeiro, Brazil 2008.

G.M. Bright¹, W.V.Moore², J.Nguyen³, G. Kletter⁴, B. S. Miller⁵, Q. L. Van Meter⁶, E. Humphriss¹, J.A. Moore⁷ and J.L. Cleland¹ Results of a Phase 1b Study of a new long-acting human growth hormone (VRS-317) in pediatric growth hormone deficiency (PGHD). PAS 2014 May 2014

Van Meter Q, Welstead B and Low J, Characteristics of a Population of Obese Children and Adolescents: Suggesting a New Paradigm, presented at ESPE meeting, Dublin 2014.

Wayne V. Moore¹, Patricia Y. Fechner², Huong Jil Nguyen³, Quentin L. Van Meter⁴, John S. Fuqua⁵, Bradley S. Miller⁶, David Ng⁷, Eric Humphriss⁸, R. W. Charlton⁸, George M. Bright⁸ Safety and Efficacy of Somavaratan (VRS-317), a Long-Acting rhGH, in Children with Growth Hormone Deficiency (GHD): 3-Year Update of the VERTICAL & VISTA Trials, presented at the 2017 Endocrine Society meeting in Orlando FL

Bradley S. Miller¹, Wayne V. Moore², Patricia Y. Fechner³, Huong Jil Nguyen⁴, Quentin L. Van Meter⁵, John S. Fuqua⁶, David Ng⁷, Eric Humphriss⁸, R. W. Charlton⁸, George M. Bright⁸, 3-Year Update of the Phase 2a and Long-term Safety Studies (VERTICAL and VISTA) of Somavaratan (VRS-317), a Long-acting rhGH for the Treatment of Pediatric Growth Hormone Deficiency, presented at the 2017 IMPE meeting in Washington D.C.

ADDITIONAL PRESENTATIONS/LECTURES:

Pediatrics Update, CME Associates, San Diego – Orlando Annual Conferences: Lectures on Pediatric Endocrine Subjects – 1986 – 2001. Course Moderator, 1997, 1998, 1999, 2000, 2001

Endocrine and Gastroenterology Update, CME Associates, Maui HI Nov 2001, Lecturer and Course Moderator

Lecture on Panhypopituitarism, Pharmacia Conference, Nashville TN April 2002.

Family Medicine Review Course, Orlando, FL, 1992 – 2001

Pediatric Grand Rounds, Tanner Medical Center, October 1997

Pediatric Grand Rounds, Hughes Spaulding Children's Hospital, September, 2003

Pediatrics in the Park, Fall CME meeting for the Georgia Chapter of the American Academy of Pediatrics, November 2003

Pediatric Grand Rounds, Columbus Regional Medical Center, January 2004

Frontiers in Pediatrics CME Course, sponsored by the Atlanta Children's Health Network, Atlanta, March 2004.

Pediatric Grand Rounds, Eggleston Children's Hospital, May 2004.

Sue Schley Matthews Pediatric Conference, Columbus Regional Medical Center, September 2004

56th Annual Scientific Assembly and Exhibition of the Georgia Academy of Family Physicians, Nov 2004

Program Co-Chairman: Southern Pediatric Endocrine Society Annual meeting, Nov 2004, November 2014

Presentations on Diabetes, Growth Failure, and Thyroid Disease to the Postgraduate Pediatric Nurse Practitioner Program, Georgia State University, Nov 2005, June 2006, May 2007

Issues in Medicine, US Medical Congress Conference and Exhibition, Las Vegas, meeting planner and speaker, June, 2006

CME Presentations for the Georgia Chapter of the American Academy of Pediatrics Spring and Fall Meetings 2004-present

Pediatric Grand Rounds, Columbus Regional Medical Center, Columbus, GA, 2011-present

Human Growth Foundation Regional CME Conference, Atlanta GA
March 2013, February 2014 Columbus Georgia

International Federation of Therapeutic Counseling Choice: Transgender Medicine, IFTCC Launch, October 15, 2018 London, Third International Congress, October 25 2018 Budapest.

Southern Pediatric Endocrine Society, Orlando FL, Feb 2019

Matthew Bulfin Conference, Indianapolis IN April 2019

CMDA annual conference, Ridgecrest NC, May 2019

Support 4 Family conference, London, UK June 2019

Audio Digest Pediatrics - ① v. 41, no. 4; ② v. 41, no. 20; ③ v. 43, no. 17

Audio Digest Family Practice - ① v. 42, no. 5; ② v. 44, no. 11; ③ v. 44, no. 44; ④ v. 45, no 15

Audio Digest Otolaryngology - ① v. 32, no. 14

CURRENT HOSPITAL APPOINTMENTS:

Eggleston/Scottish Rite Children's Hospitals, active
staff, Pediatric Endocrinology

PAST AND CURRENT CLINICAL RESEARCH:

2006	Sanofi-Aventis HMR1964D/3001	study completed 2007
2006	Tercica MS301-	study completed 2008
2007	Tercica MS310-	study completed 2008
2007	Tercica MS306-	study completed 2010
2007	Tercica MS316-	study completed 2012
2008	EMD Serono 28358	study completed 2009
2012	Versartis 12VR2	study completed 2014
2012	Debiopharm 8206-CPP-301	study started July 2012
2013	Versartis 13 VR3	study started Dec 2013
2014	Novo-Nordisk Elipse	study started 2014
2015	Versartis 14 VR4	study completed 2017
2017	Mannkind MKC-TI-155	study completed 2019
2018	Abbvie M16-904	study started 2018
2019	Novo-Nordisk Real-4	study started 2019
2019	Lilly 18B-MC-ITSB	study started 2019
2021	Pfizer PROGRES	study started 2021

2021	Lumos OragrowtH210	study started July 2021
2022	Novo-Nordisk Real-8	study starts July 2022

LEGAL EXPERT WITNESS:

2017 North Carolina Legislature- transgender bathroom bill
2018 Jessica Siefert transgender case, Cincinnati, OH
2018 Alberta, Canada school system transgender case
2018 Decatur GA School Board transgender case
2019 British Columbia transgender case
2019 Gavin Grimm transgender case, Gloucester County, VA
2019 Rowe vs Isle of Wight School Board, UK
2019 Younger transgender case, Dallas, TX
2020 Alabama State House and Senate committee hearings
2020 Pennsylvania State House Health Subcommittee hearings
2020 Iowa State House committee hearing
2020 California State House committee hearing
2020 Harris County TX custody case
2021 Missouri State House committee hearing
2021 NAACP v State of Arkansas