IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY

JANE DOE 1, *et al.*, *Plaintiffs*, v. WILLIAM C. THORNBURY, JR., MD, in his official capacity as the President of the Kentucky Board of Medical Licensure, *et al.*, *Defendants.*	No. 3:23-cv-00230-DJH

PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTIVE RELIEF

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INTRODUCTION

Section 4 of Kentucky's recently enacted Senate Bill 150 ("SB 150") will go into effect on June 29, 2023. Section 4(2)(a) and (b) will forbid healthcare providers from providing adolescent transgender patients medically necessary treatments for gender dysphoria, including hormone therapy and puberty blockers (the "Treatment Ban"). This will cause irreparable physical and mental harm to Plaintiffs—transgender minors ("Minor Plaintiffs") and their parents ("Parent Plaintiffs)—and transgender youth across Kentucky. The Treatment Ban not only is cruel; it violates the fundamental due process rights of parents to obtain established medical care for their children and denies transgender minors equal protection of the laws.

Several federal courts have enjoined substantively similar bans for precisely these reasons. "Parents, pediatricians, and psychologists—not the State or this Court—are best qualified to determine whether transitioning medications are in a child's best interest on a case-by-case basis." *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1146 (M.D. Ala. 2022), *appeal filed*, No. 22-11707 (11th Cir.); *accord Brandt v. Rutledge*, 551 F. Supp. 3d 882, 892 (E.D. Ark. 2021), *aff'd*, 47 F.4th 661 (8th Cir. 2022). The Treatment Ban will force Minor Plaintiffs "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." *Brandt*, 551 F. Supp. 3d at 892; *see also Eknes-Tucker*, 603 F. Supp. 3d at 1150 ("[W]ithout transitioning medications, Minor Plaintiffs will suffer severe medical harm, including anxiety, depression, eating disorders, substance abuse, self-harm, and suicidality.").

This Court should follow the growing weight of authority and enter a preliminary injunction against enforcement of the Treatment Ban.[1] As set forth below, all the requirements for a preliminary injunction are satisfied here.

First, Plaintiffs are likely to succeed on the merits of their claims that the Treatment Ban violates the Equal Protection Clause and the Due Process Clause of the Fourteenth Amendment. The Equal Protection Clause requires heightened scrutiny of laws like the Treatment Ban that expressly discriminate on the basis of sex, and it prohibits such discrimination absent an "exceedingly persuasive" justification. *United States v. Virginia*, 518 U.S. 515, 531 (1996). Because the government cannot discriminate against an individual for being transgender "without discriminating against that individual based on sex," *Bostock v. Clayton Cnty*., 140 S. Ct. 1731, 1741 (2020), laws that discriminate against transgender people must be "substantially related to a sufficiently important governmental interest," *City of Cleburne v. Cleburne Living Ctr*., 473 U.S. 432, 441 (1985). Here, the Treatment Ban targets transgender adolescents, denying them medically necessary care because of their gender nonconformity, and no important state interest supports the Treatment Ban.

In addition, the Due Process Clause protects parents' rights "to seek and follow medical advice" to safeguard their children's health. *Parham v. J.R*., 442 U.S. 584, 602 (1979); *see Brandt v. Rutledge*, 551 F. Supp. 3d 882, 892 (E.D. Ark. 2021) ("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.").

[1] The parties have separately tendered a proposed agreed order to expedite the briefing schedule pursuant to Local Rule 7.1. However, if the Court is unable to rule on Plaintiffs' motion for preliminary injunction before June 29, 2023, when the Treatment Ban is scheduled to go into effect, Plaintiffs request a temporary restraining order to preserve the status quo pending entry of a preliminary injunction.

Kentucky's interference with that right is subject to—and fails—strict scrutiny. Far from narrowly tailored to serve a compelling government interest, the Treatment Ban is sweeping and categorical, prohibiting any use of transitioning medications to treat gender dysphoria in transgender adolescents regardless of individual circumstance or medical need, and notwithstanding their demonstrated safety and efficacy. The Treatment Ban contradicts scientific evidence and established medical standards and undermines, rather than advances, any interest in protecting transgender youth by denying them care that is appropriate and necessary for their physical and mental health. *See, e.g.*, *Brandt*, 551 F. Supp. 3d at 891, 893 (holding Arkansas's ban of established medical treatments for transgender youth failed even rational basis review, much less the strict scrutiny).

Second, because the Treatment Ban violates Plaintiffs' constitutional rights, they will suffer irreparable harm as a matter of law without a preliminary injunction. *See Obama for Am. v. Husted*, 697 F.3d 423, 436 (6th Cir. 2012). Moreover, Minor Plaintiffs currently receive this medically necessary treatment, and their health and wellbeing will be irreparably damaged if the Commonwealth forces their treatment to stop. Further, Parent Plaintiffs, who already carefully determined that this care is necessary for their children, will be forced to watch their children suffer from an entirely preventable denial of care.

Finally, the balance of the equities decisively favors a preliminary injunction. Minor Plaintiffs and other transgender adolescents in Kentucky have been receiving the medical treatments prohibited by the Treatment Ban for months or even years without ill effect to themselves or anyone else, and an injunction to preserve the status quo during this litigation will not harm the Commonwealth. On the other hand, Plaintiffs will be denied necessary medical care

in violation of their constitutional rights in the absence of an injunction. For these reasons and the reasons below, the Court should issue a preliminary injunction.

BACKGROUND

I. MEDICAL TREATMENT FOR ADOLESCENTS WITH GENDER DYSPHORIA IS BACKED BY RESEARCH AND CONSISTENT WITH ESTABLISHED STANDARDS OF CARE.

"Gender identity" is the medical term for a person's internal, innate sense of belonging to a particular sex. Declaration of Dr. Daniel Shumer ("Shumer Decl.") ¶ 25; Declaration of Dr. Aron Janssen ("Janssen Decl.") ¶ 17. The medical term "transgender" refers to individuals whose gender identity does not align with their sex assigned at birth. Shumer Decl. ¶ 25. A transgender boy is a youth whose assigned sex at birth was female but whose gender identity is male; a transgender girl is a youth whose assigned sex at birth was male but whose gender identity is female. Scientific research and medical literature across disciplines demonstrate that gender identity has a strong biological foundation, with some studies showing that gender identity has a genetic component. *Id.* ¶¶ 28–32.

"Gender dysphoria" is a widely recognized, serious medical condition occurring when a person's gender identity and assigned sex are incongruous. Declaration of Dr. Suzanne Kingery ("Kingery Decl.") ¶ 23. The condition causes "clinically significant distress or impairment in social, occupational, or other important areas of functioning." *Id.* Living in a manner consistent with one's gender identity is critical to *every person's* health and wellbeing, including transgender people. Shumer Decl. ¶ 26; Janssen Decl. ¶ 18. Efforts to "cure" transgender individuals by forcing their gender identity into alignment with their assigned sex are "harmful and ineffective" and are considered unethical by all major associations of medical and mental health professionals. Shumer Decl. ¶ 27; Janssen Decl. ¶ 20.

To be diagnosed with gender dysphoria, a minor patient generally must satisfy criteria set forth in AM. PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION, TEXT REVISION (2022), known as the "DSM-5-TR." Specifically, the patient's incongruence between assigned sex and gender identity must persist for at least six months and manifest as two or more of the following: a marked incongruence between one's experienced/expressed gender and assigned sex; a strong desire to be rid of one's natal sex characteristics because of the marked incongruence; a strong desire for the sex characteristics of the other gender; a strong desire to be of the other gender; a strong desire to be treated as the other gender; and a strong conviction that one has the typical feelings and reactions of the other gender. Shumer Decl. ¶ 35.

The major medical associations in the United States, including the American Academy of Pediatrics ("AAP"), the Endocrine Society, the American Medical Association ("AMA"), the American Psychological Association, the American Psychiatric Association, and the American Academy of Family Physicians, among others, all recognize that adolescents with gender dysphoria may require medical intervention to treat the severe distress the condition causes. *Id.* ¶¶ 50–53; Kingery Decl. ¶ 25. Denial of medically necessary treatment for gender dysphoria causes many transgender minors to develop serious co-occurring mental health conditions, such as anxiety and depression, eating disorders, substance abuse, self-harm, and suicidality. Shumer Decl. ¶ 39. Gender dysphoria is highly treatable. *Id.* When they have access to appropriate medical care, along with parental and societal support, transgender minors are more likely to "thrive and grow into healthy adults." *Id.* ¶ 40; *see also* Kingery Decl. ¶¶ 67, 73.

Standards of care for treating transgender minors diagnosed with gender dysphoria initially were developed by the World Professional Association for Transgender Health ("WPATH"), an

international, multidisciplinary professional association with a mission to promote evidence--based care and research for transgender health, including the treatment of gender dysphoria. Shumer Decl. ¶ 37; Kingery Decl. ¶ 25; *see also WPATH Standards of Care for the Health of Transgender & Gender Diverse People, Version 8*, INT'L J. OF TRANSGENDER HEALTH (2022) ("WPATH SOC 8"). The Endocrine Society has promulgated a similar standard of care and clinical practice guidelines for the provision of puberty blockers and hormone therapy as a treatment for gender dysphoria in minors and adults. Shumer Decl. ¶ 50.

The AMA, the AAP, 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 follow the WPATH and Endocrine Society standards of care and clinical practice guidelines, which are comparable to guidelines that those professional medical organizations use to treat other conditions. *Id.* ¶ 53.

Treatment of gender dysphoria reduces a transgender person's clinically significant distress by permitting them to live in alignment with their gender identity. Kingery Decl. ¶ 27. Undergoing treatment for gender dysphoria is commonly referred to as "transition" or "gender transition." *Id.*; Shumer Decl. ¶ 56. The precise treatment of gender dysphoria depends on a comprehensive biopsychosocial assessment of each patient's needs by a mental health professional and involves both social and medical components. Shumer Decl. ¶ 41; Kingery Decl. ¶ 33.

"There are no medications considered for transition until after the onset of puberty." Shumer Decl. ¶ 57; *accord* Kingery Decl. ¶ 28. For adolescents who have begun puberty, transition may involve taking prescribed medications—puberty blockers and, for older adolescents, hormone therapy—to bring the patient's body into alignment with their gender identity. Shumer Decl. ¶¶ 44, 61. For a transgender adolescent who has begun puberty, puberty

blocking medication prevents the patient from going through the physical developments associated with puberty that exacerbate the distress experienced by the incongruence between the patient's gender identity and body. *Id.* ¶ 61. The effects of puberty delaying treatment are reversible once the treatment is discontinued. *Id.* ¶ 64; Kingery Decl. ¶ 30. For older transgender adolescents, hormone therapy may also be medically necessary to bring their body into alignment with their gender identity and further treat the gender dysphoria they may experience without treatment. Kingery Decl. ¶ 32; Shumer Decl. ¶¶ 68–69.

Longitudinal studies have shown that transgender adolescents with gender dysphoria who receive essential medical care, including puberty blockers and hormones, show levels of mental health and stability consistent with those of non-transgender adolescents. Shumer Decl. ¶ 40; *see* Kingery Decl. ¶¶ 67, 73. Access to puberty blocking medications during adolescence is associated with lower rates of suicide in transgender individuals. Shumer Decl. ¶ 27. In contrast, transgender adolescents who do not receive appropriate medical care for gender dysphoria are at risk of serious harm, including dramatically increased rates of suicidality and serious depression. *Id.*

II. KENTUCKY LAWMAKERS IGNORED RESEARCH AND ESTABLISHED STANDARDS OF CARE WHEN THEY VOTED FOR THE TREATMENT BAN.

On March 16, 2023, Kentucky lawmakers passed SB 150, which includes the Treatment Ban. Governor Beshear vetoed SB 150 on March 24, 2023. The Governor explained that SB 150: (a) "will endanger the children of Kentucky" by ignoring evidence that "receipt of care dramatically reduces the rates of suicide attempts, decreases feelings of depression and anxiety, and reduces substance abuse"; (b) "will cause an increase in suicide among Kentucky's youth"; and, (c) "allows too much government interference in personal healthcare issues and rips away the freedom of parents to make medical decisions for their children." Governor Andy Beshear, *Veto*

Message from the Governor of the Commonwealth of Kentucky Regarding Senate Bill 150 of the 2023 Regular Session, Mar. 24, 2023, https://apps.legislature.ky.gov/record/23rs/sb150/veto.pdf.

On March 29, 2023, the Kentucky legislature overrode the Governor's veto. Several legislators expressed disbelief in the established science related to gender identity and the treatment of gender dysphoria. One lawmaker referred to transgender identity as "fantasy," insisting that transgender persons will "find themselves miserable from decisions that they made when they were young." Bruce Schreiner, *GOP lawmakers override Ky. Governor's veto of transgender bill*, PBS News Hour (Mar. 29, 2023), https://www.pbs.org/newshour/politics/gop-lawmakers-override-kentucky-governors-veto-of-transgender-bill. Others asserted that hormone treatments for gender dysphoria are "experiments" that cause "irreversible damage." PBS Video of Kentucky Senate Debate & Vote to Override Veto of SB 150 (Part 1) at 1:41:12–1:41:20 (Sen. Mills); *id.* at 2:00:28–2:00:30 (Sen. Williams); *id.* at 1:49:25–1:19:30 (Sen. Tichenor), https://ket.org/legislature/archives/2023/regular/senate-chambers-199498. None of these statements is supported by research.

III. THE TREATMENT BAN SINGLES OUT TRANSGENDER ADOLESCENTS.

Absent a preliminary injunction, the following Treatment Ban will go into effect on June 29, 2023:

> Except as provided in subsection (3) of this section, a health care provider shall not, for the purpose of attempting to alter the appearance of, or to validate a minor's perception of, the minor's sex, if that appearance or perception is inconsistent with the minor's sex, knowingly:
>
> (a) Prescribe or administer any drug to delay or stop normal puberty; [or]
>
> (b) Prescribe or administer testosterone, estrogen, or progesterone, in the amounts greater than would normally be produced endogenously in a healthy person of the same age and sex.

SB 150 § 4(2)(a)–(b).[2]

Under Section 4(6), health care providers may "systematically reduce[]" over time, rather than "immediately terminat[e]," administration of these drugs to transgender youth who are already receiving them when the law takes effect.

The law permits healthcare providers to prescribe the same medications to non-transgender minors for conditions other than gender dysphoria. *See id.* § 4(2)–(3). Specifically, the same medications can be prescribed or administered to treat a "[a] minor born with a medically verifiable disorder of sex development, including external biological sex characteristics that are irresolvably ambiguous" or a "minor diagnosed with a disorder of sexual development." *Id.* § 4(3).

SB 150 charges the agencies that license and certify healthcare providers in the Commonwealth with enforcing the Treatment Ban. These agencies "shall revoke [a] health care provider's licensure or certification," if, after completion of the agency's disciplinary and hearing process, they find the provider violated the Treatment Ban. *Id.* § 5.

In sum, the Treatment Ban will forbid healthcare providers—including doctors, nurse practitioners, nurses, and physician assistants—from providing medically necessary treatments to transgender adolescents like Minor Plaintiffs, while allowing them to provide the same treatments to non-transgender adolescents.

IV. THE TREATMENT BAN WILL INFLICT SEVERE AND IRREPARABLE HARM UPON PLAINTIFFS.

The Treatment Ban will cause irreparable physical and psychological harm to transgender adolescents diagnosed with gender dysphoria in Kentucky, including Minor Plaintiffs. The Ban

[2] SB 150 also includes a ban on surgeries for transgender minors, which Plaintiffs do not challenge. Compl. ¶ 39, n. 5, ECF. No. 2.

will terminate their access to necessary medical treatment and impose additional harms on their parents and medical providers. Janssen Decl. ¶ 49.

Just as the harm caused by a prohibition on diabetes treatment would not be mitigated by tapering a diabetic child off insulin, this irreparable harm is not mitigated simply because SB 150 allows some transgender adolescents to be tapered off their medicines. To the contrary, a transgender minor who has been receiving and benefitting from these medications and who is then required to stop taking them (either immediately or over time) "will suffer and their mental health will deteriorate." Kingery Decl. ¶¶ 53, 68. There are no medical standards of care for terminating or "tapering off" transitioning medications in transgender adolescents who require them.

The Doe 1 Family. John Minor Doe 1 ("JM1") is a twelve-year-old transgender boy who lives with his family in Jefferson County, Kentucky. Declaration of Jane Doe 1 ("JD1 Decl.") ¶ 4. JM1 told his family he was transgender when he was eleven years old, which at the time did not surprise his mother. *Id.* ¶ 5. When JM1 was a little boy, he asked his mother questions like: "Mom, did you always know you were a girl?" *Id.* When JM1 began puberty and started menstruating in December 2021, his mental health declined dramatically. He became suicidal during and around his menstrual cycle. In spring 2022, after his second menstrual period, JM1's parents hospitalized him because he told a classmate he wanted to die. *Id.* ¶ 6.

In fall 2022, JM1 was diagnosed with gender dysphoria, following hours of interviews with therapists, psychiatrists, a pediatric nurse practitioner, and an endocrinologist. *Id.* ¶ 7. JM1's parents continue to work closely with his doctors in Kentucky to manage his depression and suicidality, and in November 2022, he began taking puberty blockers to stop his menstrual periods. *Id.* ¶ 8. JM1's parents saw an immediate improvement in his emotional and mental health, and they attribute a dramatic reduction in his suicidality to this medication. *Id.* JM1's parents fear that

if the Treatment Ban goes into effect, their son will be deprived of a "lifesaving and life changing" treatment, and they don't know if their family will be able to obtain treatment for him outside of Kentucky. *Id.* ¶ 9.

The Doe 2 Family. John Minor Doe 2 ("JM2") is a fifteen-year-old transgender boy who resides with his family in the Eastern District of Kentucky. Declaration of John Doe 2 ("JD2 Decl.") ¶ 4. JM2 was identified as female at birth, but as early as the first grade would ask to be called by a male name and male pronouns; he has always preferred "boy's" clothes; and, from a young age, he periodically questioned whether something was "wrong" with him. JM2 "came out" as a boy at home and at school in about the seventh or eighth grade, at which point he began to socially transition. *Id.* ¶ 6.

When JM2 began puberty and started menstruating, he felt depressed and distressed by the mismatch between his body and gender identity. *Id.* After many evaluations and careful discussions with doctors in Kentucky regarding the risks and benefits of treatment, JM2 began receiving medications to treat his gender dysphoria, including birth control pills to stop his periods and testosterone treatment. He continues to receive this treatment in Kentucky, and he also sees a therapist. *Id.* ¶ 7. Hormone therapy has significantly improved JM2's mood and sense of self. JM2 feels tremendous pride when he sees his body changing to match his male identity. *Id.* ¶ 8. JM2 has not experienced any negative impacts from hormone therapy. *Id.*

JM2's father believes that if the Treatment Ban goes into effect and prevents JM2 from continuing his treatment with birth control and testosterone, he will revert to his previous distressed mental state. *Id.* ¶ 9. JM2's father does not know whether he will be able to obtain the required treatments for his son outside of Kentucky.

The Doe 3 Family. Jane Minor Doe 3 ("JM3") is an eleven-year-old transgender girl who lives with her family in Jefferson County, Kentucky. Declaration of Jane Doe 3 ("JD3 Decl.") ¶¶ 3–4. Though she was identified as male at birth, JM3 has known since a very young age that she is a girl. She started asking for "girl's" clothes when she was six; she grew out her hair and stopped using her birth name when she was nine. *Id.* ¶ 5. She "came out" to her parents as a girl in March 2022. Because of the stigma associated with being transgender, her parents have feared for her safety. At the start of fifth grade, JM3 began to socially transition. Although she faces some bullying at school and has been rejected by some family members, she has mostly been accepted by her peers and family. *Id.* ¶ 7.

JM3 has been under the care of a psychologist in Kentucky and receives treatment for gender dysphoria and generalized anxiety disorder. *Id.* ¶ 8. JM3's psychologist diagnosed her with gender dysphoria in spring 2022 and referred her to a pediatric endocrinologist. *Id.* ¶ 9. The endocrinologist in Kentucky prescribed JM3 puberty blockers after explaining the risks associated with the treatment and evaluating her motivations and comprehension of the procedure. *Id.* ¶ 11. JM3 continues to receive treatment from an endocrinologist in Kentucky, and her next appointment will be in June 2023. *Id.* ¶ 12. JM3's endocrinologist has informed her and her family that she will not be able to continue to treat JM3 if the Treatment Ban goes into effect on June 29, 2023, and her parents do not know if they will be able to obtain care for her outside of Kentucky. *Id.* ¶ 13. Puberty blockers have made JM3's gender dysphoria and anxiety symptoms more manageable, and her parents fear the physical, emotional, and psychological consequences of

discontinuing them. *Id.* ¶ 14. JM3's parents worry that her symptoms of distress will return without continued treatment if the Treatment Ban goes into effect. *Id.*

The Doe 5 Family. John Minor Doe 5 ("JM5") is a sixteen-year-old transgender boy who lives with his family in Kentucky. Declaration of Jane Doe 5 ("JD5 Decl.") ¶ 4. JM5 was identified as female at birth, but has known since a young age that he is a boy. *Id.* ¶ 5. At age eleven, he started to wear his hair short and dress more androgynously. *Id.* ¶ 6. JM5 began using a male name and male pronouns while he was in the seventh grade, and "came out" as transgender while in the eighth grade. Because of the stigma associated with transgender identity, JM5's parents have feared for his safety. *Id.* When JM5 began puberty and started menstruating, he experienced extreme distress. *Id.* ¶ 7. His parents took him to a gynecologist to discuss possible treatment options, who prescribed medication to stop JM5's periods. *Id.* After providing detailed information regarding treatment options and associated risks, a physician recommended that JM5 be prescribed testosterone. *Id.* ¶¶ 7–8. He continues to receive this care within the Commonwealth, in addition to seeing a therapist. *Id.* ¶ 9.

JM5's parents almost immediately noticed a positive change in his mental health after he started testosterone treatment—he is happier, more confident, and more outgoing. *Id.* ¶ 10. JM5's parents are very concerned for his welfare if the Treatment Ban prevents him from continuing his testosterone treatment in Kentucky. *Id.* They do not know whether they will be able to obtain care for him outside of Kentucky if the Treatment Ban goes into effect and prohibits his treatments, and they worry his symptoms of distress will return. *Id.*

ARGUMENT

A preliminary injunction is warranted where the movant is likely to succeed on the merits and the balance of equities favor preserving the status quo while the litigation proceeds. *City of Pontiac Retired Emps. Ass'n v. Schimmel*, 751 F.3d 427, 430 (6th Cir. 2014) (en banc). The

equitable factors the Court balances are irreparable harm to the movant without an injunction, any substantial harm an injunction would cause a non-movant, and the public interest. *Id.* "When a party seeks a preliminary injunction on the basis of a potential constitutional violation, the likelihood of success on the merits often will be the determinative factor." *Obama for Am.*, 697 F.3d at 436 (cleaned up). Under this settled standard, a preliminary injunction barring the Treatment Ban from going into effect on June 29, 2023, is warranted.

However, if the Court is unable to resolve this preliminary injunction motion before June 29, 2023, the Court should enter a temporary restraining order against the Treatment Ban to preserve the status quo, prevent irreparable harm to Plaintiffs, and protect the Court's subject matter jurisdiction while it considers whether a preliminary injunction should issue. *See Ne. Ohio Coal. for the Homeless v. Blackwell*, 467 F.3d 999, 1005 (6th Cir. 2006) ("TROs are of a short duration and usually terminate with a ruling on a preliminary injunction."). The same factors guide courts' decisions to issue temporary restraining orders as preliminary injunctions. *See Certified Restoration Dry Cleaning Network, LLC v. Tenke Corp*., 511 F.3d 535, 542 (6th Cir. 2007).

I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THEIR CLAIM THAT THE TREATMENT BAN VIOLATES THE EQUAL PROTECTION CLAUSE.

A. The Treatment Ban Is Subject To Heightened Constitutional Scrutiny.

The Equal Protection Clause forbids the States from "deny[ing] to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1. State laws that single out particular groups for less favorable treatment implicate this constitutional right. More rigorous constitutional scrutiny is given to laws that single out suspect or quasi-suspect classes of persons. *See, e.g.*, *Shelby Cnty. Deputy Sheriffs' Ass'n v. Gilless*, 67 F. App'x 860, 863 (6th Cir. 2003); *Love v. Beshear*, 989 F. Supp. 2d 536, 547 (W.D. Ky. 2014).

The Treatment Ban targets an identifiable group—*transgender* minors—for less favorable treatment. Although the Treatment Ban does not use the term "transgender," it bans the listed medications only when used to "alter the appearance of, or to validate a minor's perception of, the minor's sex, if that appearance or perception is inconsistent with the minor's [birth] sex." SB 150 § 4(2). Having an "appearance or perception" of one's sex that is "inconsistent with [one's birth] sex" is precisely what defines a person as transgender, and the prohibited medications are precisely what allow a transgender person to be transgender—that is, to live consistent with their gender identity rather than be forced to live in their birth sex. By singling out treatments that target the defining feature of what it means to be transgender—that is, living consistent with a person's gender identity rather than their birth sex—the Treatment Ban singles out transgender adolescents, depriving them of essential medical care because of their gender nonconformity, while permitting the same medications to be prescribed or administered for any other reason. *Id.* For two independently sufficient reasons, heightened constitutional scrutiny—rather than mere "rational basis" review—applies.

First, "all gender-based classifications" are subject to heightened scrutiny. *United States v. Virginia*, 518 U.S. 515, 555 (1996). Discrimination against transgender persons is a form of gender-based discrimination. "It is *impossible* to discriminate against a person for being … transgender without discriminating against that individual based on sex." *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1741 (2020) (emphasis added). Classifications on the basis of transgender status "cannot be stated without referencing sex." *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 608 (4th Cir. 2020). As the Sixth Circuit held nearly twenty years ago, discrimination against a person who "fails to act and/or identify with his or her gender … is no different" than other forms of gender discrimination, *Smith v. City of Salem, Ohio,* 378 F.3d 566, 575 (6th Cir. 2004), and

"easily constitute[s] a claim of sex discrimination grounded in the Equal Protection Clause," *id.* at 577; *accord Brandt,* 47 F.4th at 670; *Grimm*, 378 F.3d at 608–09; *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1051 (7th Cir. 2017);[3] *Glenn v. Brumby*, 663 F.3d 1312, 1317 (11th Cir. 2011).

Indeed, the Treatment Ban is such a gender-based classification. It prohibits medications prescribed or administered "for the purpose of attempting to alter the appearance of, or to validate a minor's perception of, the minor's *sex*, if that appearance or perception is inconsistent with the minor's *sex*" assigned at birth. SB 150 § 4(1)(a)–(b) (emphases added). A law that "prohibits transgender minors—and only transgender minors—from taking transitioning medications due to their gender nonconformity … constitutes a sex-based classification for purposes of the Fourteenth Amendment." *Eknes-Tucker,* 603 F. Supp. 3d at 1147; *accord Brandt*, 47 F.4th at 670. Heightened scrutiny applies for this reason alone.

Second, as numerous courts have recognized, transgender persons are at least a quasi--suspect class in their own right, which independently triggers heightened scrutiny. *E.g.*, *Grimm*, 972 F.3d at 611–13; *Karnoski v. Trump*, 926 F.3d 1180, 1201 (9th Cir. 2019); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 288 (W.D. Pa. 2017); *Adkins v. City of New York.,* 143 F. Supp. 3d 134, 139 (S.D.N.Y. 2015); *M.A.B. v. Bd. of Educ.*, 286 F. Supp. 3d 704, 718–22 (D. Md. 2018); *Norsworthy v. Beard*, 87 F. Supp. 3d, 1104, 1119 (N.D. Cal. 2015); *F.V. v. Barron,* 286 F. Supp. 3d 1131, 1145 (D. Idaho 2018); *Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 951–53 (W.D. Wis. 2018); *Ray v. McCloud*, 507 F. Supp. 3d 925, 937 (S.D. Ohio 2020). As these courts found, transgender people exhibit the characteristics of a quasi-suspect class: (1)

[3] *Abrogated on other grounds as recognized by Ill. Republican Party v. Pritzker*, 973 F.3d 760, 762 (7th Cir. 2020)

they have historically been subject to discrimination; (2) they have a defining characteristic that bears no relation to a person's ability to contribute to society; (3) they may be defined as a discrete group by obvious, immutable, or distinguishing characteristics; and (4) they are a minority group lacking political power. In particular:

(1) "[T]here is not much doubt that transgender people have historically been subject to discrimination including in education, employment, housing, and access to healthcare." *Bd. of Educ. v. Dep't of Educ.*, 208 F. Supp. 3d 850, 874 (S.D. Ohio 2016). They have and continue to "face discrimination, harassment, and violence because of their gender identity." *Whitaker*, 858 F.3d at 1051. "Transgender people frequently experience harassment in places such as schools (78%), medical settings (28%), and retail stores (37%), and they also experience physical assault in places such as schools (35%) and places of public accommodation (8%)," and they "are more likely to be the victim of violent crimes" than people who are not transgender. *Grimm*, 972 F.3d at 612.

(2) "[T]here is obviously no relationship between transgender status and the ability to contribute to society." *Dep't of Educ.*, 208 F. Supp. 3d at 874. "Seventeen of our foremost medical, mental health, and public health organizations agree that being transgender implies no impairment on judgment, stability, reliability, or general social or vocational abilities." *Grimm,* 972 F.3d at 612.

(3) The "characteristic of the class" of transgender persons "calls down discrimination when it is manifest." *Dep't of Educ.*, 208 F. Supp. 3d at 874 (cleaned up); *see Adkins*, 143 F. Supp. 3d at 139–40 (noting "transgender people often face backlash in everyday life when their status is discovered").

(4) There is ample evidence that transgender people, who represent "a tiny minority of the population," are politically powerless. *Dep't of Educ.*, 208 F. Supp. 3d at 874. In very recent memory, transgender soldiers were prohibited from serving in the military. Today, many states, including Kentucky, have enacted laws to deprive transgender adolescents of medically necessary healthcare, as well as laws banning transgender youth from school sports, restrooms, classroom discussions, and from changing their name or gender markers on government identity documents. *See* Maggie Astor, *G.O.P. State Lawmakers Push a Growing Wave of Anti-Transgender Bills*, N.Y. TIMES, Jan. 25, 2023, https://www.nytimes.com/2023/01/25/us/politics/transgender-laws-republicans.html. In 2023 alone, state legislatures proposed more than 150 bills targeting transgender people for negative treatment. *Id.*

B. The Treatment Ban Cannot Withstand Heightened Scrutiny.

To survive heightened scrutiny, discriminatory classifications must substantially relate to an important governmental interest. *Virginia*, 518 U.S. at 524. This standard demands an "exceedingly persuasive justification" for discrimination. *Sessions v. Morales-Santana*, 582 U.S. 47, 58 (2017). A justification based on overbroad generalizations is not sufficient, *Virginia*, 518 U.S. at 533, and any asserted justification must reflect the law's "actual purpose" when enacted, not a hypothetical rationale or one "invented *post hoc* in response to litigation," *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 730 (1982).

The Treatment Ban cannot withstand this test. *First*, denying transgender adolescents medically necessary treatments does not serve any important governmental objective. By prohibiting providers from prescribing or administering puberty delaying medications or hormone treatments to transgender adolescents, the Kentucky Legislature *overrode* generally accepted medical protocols for treatment of gender dysphoria. Based on medical research and clinical

experience, groups such as the AMA, the AAP, the Endocrine Society, and the American Academy of Child and Adolescent Psychiatry all have determined that these medications are safe, effective, and necessary treatments for adolescents with gender dysphoria. Shumer Decl. ¶ 53; Janssen Decl. ¶ 8; *see, e.g.*, WPATH SOC 8.

The medical research supporting the use of puberty blockers and hormone therapy for transgender adolescents is substantial. Medical treatment for patients diagnosed with gender dysphoria has long been recognized as standard care by major medical associations. The AMA recognizes that "standards of care and accepted medically necessary services that affirm gender or treat gender dysphoria may include mental health counseling, non-medical social transition, [and] gender-affirming hormone therapy" and that "[e]very major medical association in the United States recognizes the medical necessity of transition-related care for improving the physical and mental health of transgender people." Press Release – American Medical Association, *AMA to states: Stop interfering in health care of transgender children* (Apr. 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children. These standards of care are peer-reviewed and based on the best available science and clinical experience. Shumer Decl. ¶¶ 45–53.

In addition to lacking any basis in medical science, any purported claim that the Treatment Ban was enacted to protect health or safety is belied by the law's express allowance of the same medications when prescribed or administered to non-transgender minors for any purpose *other* than treating gender dysphoria. That strongly suggests that the Kentucky Legislature was not genuinely motivated by any concern over whether these medications are safe for use by minors, but rather by disapproval of their use for transgender minors. *See Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 547 (1993) ("A law cannot be regarded as protecting

an interest . . . when it leaves appreciable damage to that supposedly vital interest unprohibited.") (cleaned up).

Nor is a generic concern about the risks associated with these medications sufficient to withstand heightened scrutiny. The risks associated with the prohibited medications are rare for transgender and non-transgender patients alike. Shumer Decl. ¶¶ 75–76, 82, 85. Thus, while the State may attempt to "superficial[ly]" defend the Treatment Ban "as a health measure," protecting health cannot "reasonably be regarded as its purpose." *Eisenstadt v. Baird*, 405 U.S. 438, 452 (1972); *see id.* at 453 (striking down contraception ban for single people where stated health-related rationales applied equally to married people).

Of course, every medical intervention carries risks and potential benefits. Shumer Decl. ¶ 79. Weighing the risks and potential benefits of treatment for gender dysphoria is a medical judgment similar to other judgments made by healthcare providers, adolescent patients, and their parents. *Id.* There is nothing unique about the risks associated with puberty-delaying treatment or hormone therapy that justifies the wholesale prohibition of such treatments. *Id.* ¶ 82.

Second, the Treatment Ban undermines the Commonwealth's interest in safeguarding the health and safety of minors. At a bare minimum, heightened scrutiny requires that a law *advance* an important governmental interest, not impede it. *See, e.g.*, *Virginia*, 518 U.S. at 523. Denying transgender adolescents medically necessary care is harmful, not helpful. If allowed to take effect, the Treatment Ban will actively cause harm to minors, like the Minor Plaintiffs, who will be denied medically necessary care they urgently need. Without treatment to affirm their gender identity, many adolescents with gender dysphoria suffer extreme distress and elevated rates of anxiety, depression, and suicidality. Shumer Decl. ¶¶ 87–88; Janssen Decl. ¶ 48.

C. The Treatment Ban Fails Even Rational Basis Review.

Plaintiffs have a strong likelihood of success on the merits even if the Treatment Ban were evaluated under the deferential "rational basis" test. That test requires a "rational relationship between the disparity of treatment and some legitimate governmental purpose." *Heller v. Doe*, 509 U.S. 312, 320 (1993). This relationship must not be "so attenuated as to render the distinction arbitrary or irrational." *Cleburne*, 473 U.S. at 446; *see, e.g.*, *Ray v. McCloud*, 507 F. Supp. 3d 925, 939 (S.D. Ohio 2020) (rejecting Ohio's justifications for disallowing transgender people to change sex marker on birth certificate under rational basis review "because there is no logical connection between the Policy and proffered justifications").

Here, for the reasons stated above, there is no logical or rational connection between the Treatment Ban and any justifications that may be proffered by Defendants. Rather than protecting transgender minors from harm, the Treatment Ban deprives them of the only safe and effective treatments for their gender dysphoria, leaving them with *no* treatment for a serious medical condition that, when left untreated, predictably causes serious and irreparable harms. The Treatment Ban permits the same medications to be prescribed and administered to other minors, thereby belying any claim that the medications themselves are unsafe. And it imposes a sweeping and categorical ban, completely barring these treatments regardless of a minor's individual medical circumstances or needs, and regardless of the severe and even life-threatening harm that may be caused for youth who have been benefitting from these medications and now must terminate them.

In such a case, where a law imposes "a broad and undifferentiated disability on a single named group" and inflicts "immediate, continuing, and real injuries that outrun and belie any legitimate justifications that may be claimed for it," there is an "inevitable inference that the disadvantage imposed is born of animosity toward the class of persons affected." *Romer v. Evans*, 517 U.S. 620, 632, 635 (1996). Such prejudice need not reflect "malice" or a conscious intent to

harm, but "may result as well from insensitivity caused by simple want of careful, rational reflection or from some instinctive mechanism to guard against people who appear to be different in some respects from ourselves." *Bd. of Trs. of Univ. of Ala. v. Garrett*, 531 U.S. 356, 374 (2001) (Kennedy, J., concurring). Here, because the Treatment Ban singles out transgender minors in such a stark way, barring the only established treatments for their medical care, and because it will cause them to suffer such serious harms, it cannot survive any level of review. "It is not within our constitutional transition to enact laws of this sort." *Romer*, 517 U.S. at 633.

II. PLAINTIFFS' CLAIM THAT THE TREATMENT BAN VIOLATES THE DUE PROCESS CLAUSE IS LIKELY TO SUCCEED.

The Due Process Clause protects "against government interference with certain fundamental rights and liberty interests." *Washington v. Glucksberg*, 521 U.S. 702, 719–20 (1997). Where a fundamental right is at issue, strict scrutiny applies. Under strict scrutiny, a law will fail unless it is "narrowly tailored to further" a "compelling state interest." *Middleton v. City of Flint*, 92 F.3d 396, 404 (6th Cir. 1996). It is settled in this circuit that parents have a fundamental right "to direct their children's medical care," and that laws that invade that right are subject to strict scrutiny. *Kanuszewski v. Mich. Dep't of Health & Hum. Servs.*, 927 F.3d 396, 419 (6th Cir. 2019). Here, the Treatment Ban interferes with this right by barring Parent Plaintiffs from obtaining the only medically accepted, safe, and effective treatment for their transgender children.

As discussed, the Treatment Ban cannot survive heightened scrutiny or even rational basis review, so it necessarily fails the more demanding strict scrutiny. The law's categorical prohibition of medically necessary care for transgender adolescents is not narrowly tailored because it is not, by any means, the "least restrictive" way of achieving any legitimate, much less compelling, objective. *See Bernal v. Fainter*, 467 U.S. 216, 219 (1984). Moreover, any assertion that the law is intended to protect children "is pretextual because [it] allows the same treatments for non-

transgender minors that are banned for transgender minors as long as the desired results conform with the stereotype of the minor's biological sex." *Brandt*, 551 F. Supp. 3d at 893.

In sum, the Treatment Ban deprives Parent Plaintiffs of their fundamental right to obtain medical treatment for their children that their children's doctors have recommended, that has improved their children's health and wellbeing, and that every major medical association has recognized as safe, effective, and necessary. *See Brandt*, 551 F. Supp. 3d at 892 ("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."). "Parents, pediatricians, and psychologists—not the State or this Court—are best qualified to determine whether transitioning medications are in a child's best interest on a case-by-case basis." *Eknes-Tucker*, 603 F. Supp. 3d at 1146.

III. THE BALANCE OF EQUITIES FAVORS PRESERVING THE STATUS QUO AND PREVENTING THE TREATMENT BAND FROM TAKING EFFECT.

A. Plaintiffs Will Suffer Immediate And Irreparable Harm If The Treatment Ban Takes Effect.

Harm "is irreparable if it is not fully compensable by monetary damages." *Obama for Am.*, 697 F.3d at 436 (cleaned up). When constitutional rights or civil rights are threatened or impaired, as they are here, irreparable injury is presumed. *Id.*; *Dep't of Educ.*, 208 F. Supp. 3d at 878. The irreparable harm here, however, is far more than the deprivation of the Plaintiffs' constitutional rights. By enforcing the Treatment Ban, Defendants will immediately deny patients life-saving medical care by either forcing them to discontinue treatment or preventing them from initiating treatment. This will force families, like Parent Plaintiffs, to either watch their children suffer or to incur the significant expense of regular travel or relocation to access care.

As one district court has held, the following irreparable harms flow inevitably from enforcement of the Treatment Ban: (1) transgender youths face "high risk of gender dysphoria and

lifelong physical and emotional pain," and (2) parents must choose between watching their children suffer or uprooting their family to move to another state. *Brandt*, 551 F. Supp. 3d at 892; *see also Eknes-Tucker*, 603 F. Supp. 3d at 1150 (finding that transgender plaintiffs and their parents were likely to be irreparably harmed by a similar Alabama law).

Here, as a result of the Treatment Ban, JM1, JM2, JM3, and JM5 will lose access to the medical treatment that has allowed them to thrive. They and their parents are already experiencing severe anxiety and distress at the prospect of either losing care in the coming months or being forced to move. *See* JD1 Decl. ¶ 9; JD2 Decl. ¶ 9; JD3 Decl. ¶ 13; JD5 Decl. ¶ 11. The Treatment Ban will force Minor Plaintiffs to proceed through endogenous puberty despite having already made careful determinations with their doctors and parents that doing so would severely harm their mental and physical health. *See* JD1 Decl. ¶ 9; JD2 Decl. ¶ 9; JD3 Decl. ¶ 13; JD5 Decl. ¶ 11. Parent Plaintiffs can avoid this harm to their minor children only by disrupting their lives and families to travel or move elsewhere for treatment. *See* JD1 Decl. ¶ 9; JD2 Decl. ¶ 9; JD3 Decl. ¶ 13; JD5 Decl. ¶ 11. These severe harms cannot be remedied by damages: they will be irreparable.

B. An Injunction Will Not Harm Defendants And Is In The Public Interest.

The balance of equities weighs heavily in favor of Plaintiffs, who will suffer significant, irreparable harm without an injunction, whereas Defendants will not suffer any, much less a substantial, harm if an injunction issues. At most, Defendants stand to temporarily lose the ability to disrupt the status quo with a new law that does not advance any legitimate state interest and is likely to be held unconstitutional. That doesn't compare to the very real harm Plaintiffs are about to suffer. *See, e.g.*, *Martin-Marietta Corp. v. Bendix Corp.*, 690 F.2d 558, 568 (6th Cir. 1982).

Granting an injunction will undoubtedly serve the public interest. As the Sixth Circuit has made clear: "[w]hen a constitutional violation is likely . . . the public interest militates in favor of injunctive relief because it is always in the public interest to prevent violation of a party's

constitutional rights." *ACLU Fund of Mich. v. Livingston Cnty.*, 796 F.3d 636, 649 (6th Cir. 2015) (cleaned up). If this Court does not grant preliminary relief, the lives of many transgender youth and their families will be upended while the Court continues to evaluate the lawfulness of the Treatment Ban during the pendency of the litigation. *See, e.g., Planned Parenthood Inc. v. Cameron*, 2022 WL 3973263, at *9 (W.D. Ky. 2022) ("[C]ourts in the Sixth Circuit have held that public policy supports an injunction when there would be a disruption to medical services."), *appeal docketed*, (6th Circuit 2023). In contrast, because the Treatment Ban harms rather than protects transgender youth, the State will suffer no harm if the preliminary injunction is granted. *See Eknes-Tucker*, 603 F. Supp. 3d at 1151 (finding severe harm from denying access to care outweighs State's harms).

Finally, the preliminary injunction must apply statewide because the Treatment Ban prohibits necessary care for all transgender adolescents throughout the Commonwealth. *Califano v. Yamasaki,* 442 U.S. 682, 702 (1979) ("[T]he scope of injunctive relief is dictated by the extent of the violation established"). As other courts considering similar bans have done, this Court should preliminarily enjoin Defendants from enforcing the Treatment Ban.

CONCLUSION

For all of the foregoing reasons, Plaintiffs respectfully ask the Court to enter a preliminary injunction preventing enforcement of the Treatment Ban, SB 150 § 4(2)(a)–(b).

Dated: May 22, 2023

Respectfully Submitted,

/s/ Heather Gatnarek

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CERTIFICATE OF SERVICE

The undersigned certifies that the foregoing was filed with the Court using the CM/ ECF system on May 22, 2023, which will generate an electronic notice of filing to all counsel registered with that service.

/s/ Heather Gatnarek
Heather Gatnarek

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY

JANE DOE 1, et al., *Plaintiffs*, v. WILLIAM C. THORNBURY, JR., MD, et al., *Defendants*.	Civil No. 3:23-cv-00230-DJH

DECLARATION OF DANIEL SHUMER, M.D.

I, Daniel Shumer, M.D., hereby declare and state as follows:

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

2. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

I. BACKGROUND AND QUALIFICATIONS

A. Qualifications

3. I am a Pediatric Endocrinologist, Associate Professor of Pediatrics, and the Clinical Director of the Child and Adolescent Gender Clinic at Mott Children's Hospital at Michigan Medicine. I am also the Medical Director of the Comprehensive Gender Services Program at Michigan Medicine, University of Michigan.

4. I am Board Certified in Pediatrics and Pediatric Endocrinology by the American Board of Pediatrics and licensed to practice medicine in the state of Michigan.

5. I received my medical degree from Northwestern University in 2008. After completing a Residency in Pediatrics at Vermont Children's Hospital, I began a Fellowship in Pediatric Endocrinology at Harvard University's Boston Children's Hospital. Concurrent with the Fellowship, I completed a Master of Public Health from Harvard's T.H. Chan School of Public Health. I completed both the Fellowship and the MPH degree in 2015.

6. I have extensive experience in working with and treating children and adolescents with endocrine conditions including differences in sex development (DSD) (also referred to as intersex conditions), gender dysphoria, type 1 diabetes, thyroid disorders, growth problems, and delayed or precocious puberty. I have been treating patients with gender dysphoria since 2015.

7. A major focus of my clinical, teaching, and research work pertains to the assessment and management of transgender adolescents.

8. I have published extensively on the topic of gender identity in pediatrics and the treatment of gender dysphoria, as well as reviewed the peer-reviewed literature concerning medical treatments for gender dysphoria, the current standards of care for the treatment of gender dysphoria, and research articles on a variety of topics with a

focus on mental health in transgender adolescents.

9. I am involved in the education of medical trainees. I am the Fellowship Director in the Division of Pediatric Endocrinology, Education Lead for the Division of Pediatric Endocrinology, and Course Director for a medical student elective in Transgender Medicine. My additional academic duties as an Associate Professor include teaching several lectures, including those entitled "Puberty," "Transgender Medicine," and "Pediatric Growth and Development."

10. As a Fellow at Harvard, I was mentored by Dr. Norman Spack. Dr. Spack established the Gender Management Services Clinic (GeMS) at Boston Children's Hospital. While working and training at GeMS, I became a clinical expert in the field of transgender medicine within Pediatric Endocrinology and began conducting research on gender identity, gender dysphoria, and the evaluation and management of gender dysphoria in children and adolescents.

11. Based on my work at GeMS, I was recruited to establish a similar program assessing and treating gender diverse and transgender children and adolescents at the C.S. Mott Children's Hospital in Ann Arbor. In October 2015, I founded the hospital's Child and Adolescent Gender Services Clinic.

12. The Child and Adolescent Gender Services Clinic has treated over 600 patients since its founding. The clinic provides comprehensive assessment, and when appropriate, treatment with pubertal suppression and hormonal therapies, to patients

diagnosed with gender dysphoria. I have personally evaluated and treated over 400 patients with gender dysphoria. The majority of the patients receiving care range between 10 and 21 years old. Most patients attending clinic live in Michigan or Ohio. As the Clinical Director, I oversee the clinical practice, which currently includes 4 physicians (including 1 psychiatrist), 1 nurse practitioner, 2 social workers, 1 research coordinator, as well as nursing and administrative staff. I also actively conduct research related to transgender medicine, gender dysphoria treatment, and mental health concerns specific to transgender youth.

13. I also provide care in the Differences/Disorders of Sex Development (DSD) Clinic at Michigan Medicine at Mott Children's Hospital. The DSD Clinic is a multidisciplinary clinic focused on providing care to infants and children with differences in the typical path of sex development, which may be influenced by the arrangement of sex chromosomes, the functioning of our gonads (i.e. testes, ovaries), and our bodies' response to hormones. The clinic is comprised of members from Pediatric Endocrinology, Genetics, Psychology, Urology, Gynecology, Surgery, and Social Work. In this clinic I have assessed and treated over 100 patients with DSD. In my role as Medical Director of the Comprehensive Gender Services Program (CGSP), I lead Michigan Medicine's broader efforts related to transgender services. CGSP is comprised of providers from across the health system including pediatric care, adult hormone provision, gynecologic services, adult surgical services, speech/language

therapy, mental health services, and primary care. I run monthly meetings with representatives from these areas to help coordinate communication between Departments. I coordinate strategic planning aimed to improve care within the health system related to our transgender population. I also serve as the medical representative for CGSP in discussions with health system administrators and outside entities.

14. I have authored numerous peer-reviewed articles related to treatment of transgender youth. I have also co-authored chapters of medical textbooks related to medical management of transgender patients. I have been invited to speak at numerous hospitals, clinics, and conferences on topics related to clinical care and standards for treating transgender children and youth.

15. The information provided regarding my professional background, experiences, publications, and presentations is detailed in my curriculum vitae, a true and correct copy of the most up-to-date version of which is attached as **Exhibit A**.

B. Prior Testimony

16. In the past four years, I have been retained as an expert and provided testimony at trial or by deposition in the following cases: *Roe et al v. Utah High School Activities Association et al* (Third District Court in and for Salt Lake County, UT); *Menefee v. City of Huntsville Bd. of Educ.*, No. 5:18-cv-01481 (N.D. Ala.); *Dekker v. Weida*, No. 4:22 cv 00325 RH MAF (N.D. Fla.); and *Cooper v. USA Powerlifting and Powerlifting Minnesota*, No.62-CV-21-211 (Minnesota District Court, Ramsey

Couthy Second Judicial District). I also provided expert witness testimony on behalf of a parent in a custody dispute involving a transgender child in the following case: *In the Interest of Younger*, No. DF-15-09887 (Dallas County, Texas).

C. Compensation

17. 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, 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.

D. Bases for Opinions

18. In preparing this declaration, I reviewed the text of Kentucky Senate Bill 150, which I understand was enacted over the Governor's veto in March 2023.

19. I have also reviewed the materials listed in the bibliography attached as **Exhibit B** to this report, as well as the materials listed within my curriculum vitae, which is attached as **Exhibit A**. The sources cited therein include authoritative, scientific peer-reviewed publications. They include the documents specifically cited as supportive examples in particular sections of this report. I may rely on these materials as additional support for my opinions.

20. In addition, I have relied on my scientific education, training, and years of clinical and research experience, and my knowledge of the scientific literature in the

pertinent fields.

21. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on these subjects.

22. To the best of my knowledge, I have not met or spoken with the Plaintiffs or their parents. My opinions are based solely on my extensive background and experience treating transgender patients.

23. I may wish to supplement or revise these opinions or the bases for them due to new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

II. EXPERT OPINIONS

A. MEDICAL AND SCIENTIFIC BACKGROUND ON SEX AND GENDER IDENTITY

24. *Sex* is comprised of several components, including, among others, internal reproductive organs, external genitalia, chromosomes, hormones, gender identity, and secondary sex characteristics (IOM, 2011).

25. *Gender identity* is the medical term for a person's internal, innate sense of belonging to a particular sex. Everyone has a gender identity. Diversity of gender identity and incongruence between assigned sex at birth and gender identity are naturally occurring sources of human biological diversity (IOM, 2011). The term *transgender* refers to individuals whose gender identity does not align with their sex

assigned at birth (Shumer, et al., 2013).

26. The terms *gender role* and *gender identity* refer to different things. *Gender roles* are behaviors, attitudes, and personality traits that a particular society considers masculine or feminine, or associates with male or female social roles. For example, the convention that girls wear pink and have longer hair, or that boys wear blue and have shorter hair, are socially constructed gender roles from a particular culture and historical period. By contrast, *gender identity* does not refer to socially contingent behaviors, attitudes, or personality traits. It is an internal and largely biological phenomenon, as reviewed below. Living consistent with one's gender identity is critical to the health and well-being of any person, including transgender people (Hidalgo, et al., 2013; Shumer, et al., 2013; White Hughto, et al., 2015).

27. A person's understanding of their gender identity may evolve over time in the natural course of their life, however, attempts to "cure" transgender individuals by forcing their gender identity into alignment with their birth sex has been found to be both harmful and ineffective. In one study, transgender adults who recall previous attempts from healthcare professionals to alter their gender identity reported an increase in lifetime suicide attempts and higher rates of severe psychological distress in the present (Turban, et al., 2020a). In another study, exposure to these types of attempts were found to increase the likelihood that a transgender adolescent will attempt suicide by 55% and more than double the risk for running away from home (Campbell, et al.,

2002). Those practices have been denounced as unethical by all major professional associations of medical and mental health professionals, such as the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, and the American Psychological Association, among others (Fish, et al., 2022).

28. Scientific research and medical literature across disciplines demonstrates that gender identity, like other components of sex, has a strong biological foundation. For example, there are numerous studies detailing the similarities in the brain structures of transgender and non-transgender people with the same gender identity (Luders, et al., 2009; Rametti, et al., 2011; Berglund, et al., 2008; Savic, et al., 2011). 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 non-transgender women (Chung, et al., 2002).

29. There are also studies highlighting the genetic components of gender identity. Twin studies are a helpful way to understand genetic influences on human diversity. Identical twins share the same DNA, while fraternal twins share roughly 50% of the same DNA, however both types of twins share the same environment. Therefore, studies comparing differences between identical and fraternal twin pairs can help isolate the genetic contribution of human characteristics. Twin studies have shown that if an identical twin is transgender, the other twin is much more likely to be

transgender compared to fraternal twins, a finding which points to genetic underpinnings to gender identity development (Heylens, et al., 2012).

30. There is also ongoing research on how differences in fetal exposures to hormones may influence gender identity. This influence can be examined by studying a medical condition called congenital adrenal hyperplasia. Female fetuses affected by congenital adrenal hyperplasia produce much higher levels of testosterone compared to fetuses without the condition. While most females with congenital adrenal hyperplasia have a female gender identity in adulthood, the percentage of those with gender dysphoria is higher than that of the general population. This suggests that fetal hormone exposures contribute to the later development of gender identity (Dessens, et al, 2005).

31. There has also been research examining specific genetic differences that appear associated with gender identity formation (Rosenthal, 2014). For example, one study examining differences in the estrogen receptor gene among transgender women and non-transgender male controls found that the transgender individuals were more likely to have a genetic difference in this gene (Henningsson, et al., 2005).

32. The above studies are representative examples of scientific research demonstrating biological influences on gender identity. Gender identity, like other complex human characteristics, is rooted in biology with important contributions from neuroanatomic, genetic and hormonal variation (Roselli, 2018).

B. RATIONALE FOR MEDICAL TREATMENT OF GENDER DYSPHORIA IN ADOLECENTS

33. All medical interventions, including treatment for gender dysphoria, require rigorous study and evidence base.

34. There are several studies demonstrating positive results of gender-affirming care in adolescents (de Vries, et al., 2014; de Vries, et al., 2011; Green, et al., 2022; Smith, et al., 2005; Turban, et al., 2022). These studies consistently demonstrate improvement of gender dysphoria with associated improvement of psychological functioning. A 2014 long-term follow-up study following patients from early adolescence through young adulthood showed that gender-affirming treatment allowed transgender adolescents to make age-appropriate developmental transitions while living as their affirmed gender with positive outcomes as young adults (de Vries, et al., 2014). More recently, Green et al. (2022) describe that gender-affirming hormone therapy is correlated with reduced rates of depression and suicidality among transgender adolescents. Turban et al. (2022) documented that access to gender-affirming hormone therapy in adolescence is associated with favorable mental health outcomes in adulthood, when compared to individuals who desired but could not access hormonal interventions.

C. ASSESSMENT OF GENDER DYSPHORIA IN CHILDREN AND ADOLESCENTS

35. Due to the incongruence between their assigned sex and gender identity, transgender people experience varying degrees of gender dysphoria, a serious medical condition defined in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5 TR) (APA, 2022). *Gender Dysphoria* is defined as an incongruence between a patient's assigned sex and their gender identity present for at least six months, which causes clinically important distress in the person's life. This distress is further defined as impairment in social, occupational, or other important areas of functioning (APA, 2022). Additional features may include a strong desire to be rid of one's primary or secondary sex characteristics, a strong desire to be treated as a member of the identified gender, or a strong conviction that one has the typical feelings of identified gender (APA, 2022).

36. The World Health Organization's International Classification of Diseases (ICD), the diagnostic and coding compendia for mental health and medical professionals, codifies Gender Incongruence as the diagnosis resulting from the incongruity between one's gender identity and birth sex. The Gender Incongruence diagnosis is part of a new "Conditions related to sexual health" chapter in the ICD-11, which is the most recent iteration of the ICD published in 2019 (Costa, et al., 2015; WHO, 2019). This reflects evidence that transgender and gender diverse identities are not conditions of mental ill health and classifying them as such can cause enormous

stigma.

37. In children and adolescents, the diagnosis of gender dysphoria is made by a health provider including but not limited to a psychiatrist, psychologist, social worker, or therapist with expertise in gender identity concerns. It is recommended that children and adolescents diagnosed with gender dysphoria engage with a multidisciplinary team of mental health and medical professionals to formulate a treatment plan, in coordination with the parent(s) or guardian(s), with a goal of reduction of gender dysphoria. The *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8* ("SOC 8"), published by the World Professional Association for Transgender Health (WPATH), provides guidance to providers on how to provide comprehensive assessment and care to this patient population based on medical evidence. These standards recommend involving relevant disciplines, including mental health and medical professionals, to reach a decision with families about whether medical interventions are appropriate and remain indicated through the course of treatment. Multidisciplinary clinics, such as the Child and Adolescent Gender Clinic where I practice, have structured their programs around this model, as guided by the WPATH SOC.

D. EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES FOR THE TREATMENT OF GENDER DYSPHORIA IN CHILDREN, ADOLESCENTS

38. The goal of any intervention for gender dysphoria is to reduce dysphoria,

improve functioning, and prevent the harms caused by untreated gender dysphoria.

39. Gender dysphoria is highly treatable and can be effectively managed. If left untreated, however, it can result in severe anxiety and depression, eating disorders, substance abuse, self-harm, and suicidality (Reisner, et al., 2015).

40. Based on longitudinal data, and my own clinical experience, when transgender adolescents are provided with appropriate medical treatment and have parental and social support, they are more likely to thrive and grow into healthy adults (de Vries, et al., 2014).

41. In children and adolescents, a comprehensive biopsychosocial assessment is typically the first step in evaluation, performed by a mental health provider with experience in gender identity. The goals of this assessment are to develop a deep understanding of the young person's experience with gender identity, to consider whether the child or adolescent meets criteria for a diagnosis of gender dysphoria, and to understand what options may be desired and helpful for the adolescent (Coleman, et al., 2022; Coleman, et al., 2012; Hembree, et al., 2017; Hembree, et al., 2009).

42. For children younger than pubertal age, the only recommended treatments do not involve medications. For adolescents, additional treatments involving medications may be appropriate.

43. For pre-pubertal children with gender dysphoria, treatments may include

supportive therapy, encouraging support from loved ones, and assisting the young person through elements of a social transition. Social transition may include adopting a new name and pronouns, appearance, and clothing, and correcting identity documents.

44. Options for treatment after the onset of puberty include the use of gonadotropin-releasing hormone agonists ("GnRHa") for purposes of preventing progression of pubertal development, and hormonal interventions such as testosterone and estrogen administration. These treatment options are based on robust research and clinical experience, which consistently demonstrate safety and efficacy.

45. Clinical practice guidelines have been published by several long-standing and well-respected medical bodies: the World Professional Association for Transgender Health (WPATH) and the Endocrine Society (Coleman, et al., 2022; Coleman, et al., 2012; Hembree, et al., 2017; Hembree, et al., 2009), as well as the UCSF Center for Excellence in Transgender Health (Deutsch (ed.), 2016). The clinical practice guidelines and standards of care published by these organizations provide a framework for treatment of gender dysphoria in adolescents.

46. WPATH has been recognized as the standard-setting organization for the treatment of gender dysphoria since its founding in 1979. The most recent WPATH Standards of Care (SOC 8) were published in 2022 and represent expert consensus for clinicians related to medical care for transgender people, based on the best available

science and clinical experience (Coleman, et al., 2022).

47. The purpose of the WPATH Standards of Care is to assist health providers in delivering necessary medical care to transgender people, to maximize their patients' overall health, psychological well-being, and self-fulfillment. The WPATH Standards of Care serve as one of the foundations for the care provided in my own clinic.

48. The WPATH SOC 8 is based on rigorous review of the best available science and expert professional consensus in transgender health. International professionals were selected to serve on the SOC 8 writing committee. Recommendation statements were developed based on data derived from independent systemic literature reviews. Grading of evidence was performed by an Evidence Review Team which determined the strength of evidence presented in each individual study relied upon in the document (Coleman, et al., 2022).

49. The previous version (SOC 7), published in 2012 (Coleman, et al., 2012), was similar to SOC 8 in the basic tenets of management for transgender adolescents; however, SOC 8 further reinforces these guidelines with data published since the release of SOC 7.

50. In addition, 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 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, et al, 2017).

51. The Endocrine Society Clinical Guidelines were developed through rigorous scientific processes that "followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines." The guidelines affirm that patients with gender dysphoria often must be treated with "a safe and effective hormone regimen that will

(1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender." (Hembree, et al., 2017).

52. The AAP is the preeminent professional body of pediatricians in the United States, with over 67,000 members. The AAP endorses a commitment to the optimal physical, mental, and social health and well-being for youth. The 2018 policy statement titled *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents* further lends support to the treatment options outlined in the WPATH Standards of Care and the Endocrine Society's Clinical Practice Guidelines (Rafferty, et al., 2018).

53. Aside from the AAP, the tenets set forth by the Endocrine Society Clinical Practice Guidelines and the WPATH Standards of Care are supported by the major professional medical and mental health associations in the United States, including the American Medical Association, the American Psychological Association, the American Psychiatric Association, and American Academy of Family Physicians, among others (e.g., AMA, 2019; American Psychological Association, 2015; Drescher, et al., 2018 (American Psychiatric Association); Hembree, et al., 2017 (Endocrine Society); Klein, et al., 2018 (AAFP); National Academies, 2020; WPATH, 2016).

54. As a board-certified pediatric endocrinologist, I follow the Endocrine Society Clinical Practice Guidelines and the WPATH Standards of Care when treating my patients.

E. TREATMENT PROTOCOLS FOR GENDER DYSPHORIA IN CHILDREN AND ADOLESCENTS

55. Central to the guidance from WPATH, the Endocrine Society, and the AAP is the importance of familial love and support. Transgender youth who report high levels of rejection from family have lower self-esteem and higher degrees of isolation. These youth are at very high risk for health and mental health problems when they become young adults. According to the Family Acceptance Project, transgender young people who reported high levels of family rejection are significantly more likely to have attempted suicide, to report high levels of depression, to use illegal drugs, and

to be at high risk for HIV and sexually transmitted diseases compared with transgender young people who report no or low levels of rejection by family due to their identity (Ryan, et al., 2010).

56. Undergoing treatment to alleviate gender dysphoria is commonly referred to as a transition. The transition process in adolescence typically includes (i) social transition and/or (ii) medications, including puberty-delaying medication and hormone therapy. The steps that make up a person's transition and their sequence will depend on that individual's medical and mental health needs and decisions made between the patient, family, and multidisciplinary care team.

57. There are no medications considered for transition until after the onset of puberty. Puberty is a process of maturation heralded by production of sex hormones—testosterone and estrogen—leading to the development of secondary sex characteristics. Secondary sex characteristics include testosterone-induced effects such as deepening of the voice, muscular changes, facial and body hair, and estrogen-induced effects such as breast development. There is diversity in the age of pubertal onset; however, most adolescents begin puberty between ages 10 and 12 years.

58. Gender exploration in childhood is expected and healthy. The majority of prepubertal children exploring their gender do not develop gender dysphoria and are not expected to become transgender adolescents or adults. In contrast, data and personal experience shows that children whose gender dysphoria persists into

adolescence are highly likely to be transgender (van der Loos, et al., 2022). Some individuals in this field misinterpret older studies showing that a large percentage of children diagnosed with gender identity disorder did not grow up to be transgender. Those studies include children who would not fulfill the current diagnostic criteria for gender dysphoria and, in any case, have no relevance to this case because no medications are prescribed to prepubertal children.

59. Puberty-delaying medication and hormone-replacement therapy—both individually and in combination—can significantly improve a transgender young person's mental health. These treatments allow for a physical appearance more closely aligning with gender identity and decreases the likelihood that a transgender young person will be incorrectly identified with their assigned sex, further alleviating their gender dysphoria, and bolstering the effectiveness of their social transition.

60. At the onset of puberty, adolescents begin to experience the onset of secondary sex characteristics. Adolescents with differences in gender identity may have intensification of gender dysphoria during this time due to development of secondary sex characteristics incongruent with gender identity. Persistence or intensification of gender dysphoria as puberty begins is used as a helpful diagnostic tool as it becomes more predictive of gender identity persistence into adolescence and adulthood (de Vries, et al., 2012).

i. Treatment with puberty-delaying medications

61. Adolescents diagnosed with gender dysphoria who have entered puberty (Tanner Stage 2) may be prescribed puberty-delaying medications (GnRHa) to prevent the distress of developing permanent, unwanted physical characteristics that do not align with the adolescent's gender identity. Tanner Stage 2 refers to the stage in puberty whereby the physical effects of testosterone or estrogen production are first apparent on physical exam. Specifically, this is heralded by the onset of breast budding in an individual assigned female at birth, or the onset of testicular enlargement in an individual assigned male at birth. For individuals assigned male at birth, Tanner Stage 2 typically occurs between age 9-14, and for those assigned female at birth between age 8-12.

62. The treatment works by pausing endogenous puberty at whatever stage it is at when the treatment begins, limiting the influence of a person's endogenous hormones on their body. For example, a transgender girl will experience no progression of physical changes caused by testosterone, including facial and body hair, an Adam's apple, or masculinized facial structures. And, in a transgender boy, those medications would prevent progression of breast development, menstruation, and widening of the hips (Coleman, et al., 2022; de Vries, et al., 2012; Deutsch (ed.), 2016; Hembree, et al., 2017; Rosenthal, 2014).

63. GnRHa have been used extensively in pediatrics for several decades.

Prior to their use for gender dysphoria, they were used (and still are used) to treat precocious puberty. GnRHa work by suppressing the signal hormones from the pituitary gland (luteinizing hormone [LH] and follicle stimulating hormone [FSH]) that stimulate the testes or ovaries to produce sex hormones. Upon discontinuation of GnRHa, LH and FSH production resume and puberty will also resume.

64. GnRHa have no long-term implications on fertility. In transgender youth, it is most typical to use GnRHa from the onset of puberty (Tanner Stage 2) until mid-adolescence. While treating, the decision to continue treatment will be continually evaluated. Should pubertal suppression no longer be desired, GnRHa would be discontinued, and puberty would re-commence.

65. Prior to initiation of GnRHa, providers counsel patients and their families extensively on potential benefits and risks. The designed benefit of the treatment is to reduce the risk of worsening gender dysphoria and mental health deterioration. Furthermore, development of secondary sex characteristics incongruent with gender identity could result in the future need for surgeries and other body alterations that would not be needed if GnRHa had been used.

66. As an experienced pediatric endocrinologist, I treat patients with these same medications for both precocious puberty and gender dysphoria and in both cases the side effects are comparable and easily managed. And for both patient populations the risks are greatly outweighed by the benefits of treatment.

67. In addition, I regularly prescribe GnRHa for patients who do not meet criteria for precocious puberty but who require pubertal suppression. Examples include patients with disabilities who are unable to tolerate puberty at the typical age due to hygienic concerns; minors with growth hormone deficiency who despite growth hormone treatment will have a very short adult height; and young women with endometriosis. As with gender dysphoria, the prescription of GnRHa to treat these conditions is "off-label," yet it is widely accepted within the field of endocrinology and not considered experimental. The same holds true for other common medications used in pediatric endocrinology: using metformin for weight loss; growth hormone for short stature not caused by growth hormone deficiency; countless medications used to control type 2 diabetes which have an adult indication but whose manufacturers have not applied for a pediatric indication.

ii. Treatment with hormone therapy

68. In mid-adolescence, the patient, their parents, and the patient's care team may discuss the possibility of beginning the use of testosterone or estrogen. In my practice we discuss these treatments for a patient who is currently receiving GnRHa, or patients who have already gone through their endogenous puberty and either did not have access to, desire, or elect for GnRHa treatment.

69. These hormone therapies are used to treat gender dysphoria in adolescents to facilitate development of sex-specific physical changes congruent with

their gender identity. For example, a transgender boy prescribed testosterone will develop a lower voice as well as facial and body hair, while a transgender girl prescribed estrogen will experience breast growth, female fat distribution, and softer skin.

70. Under the Endocrine Society Clinical Guidelines and SOC 8, hormone therapy is an appropriate treatment for transgender adolescents with gender dysphoria when the experience of dysphoria is marked and sustained over time, the adolescent demonstrates emotional and cognitive maturity required to provide and informed consent/assent for treatment, other mental health concerns (if any) that may interfere with diagnostic clarity and capacity to consent have been addressed, the adolescent has discussed reproductive options with their provider. SOC 8 also highlights the importance of involving parent(s)/guardian(s) in the assessment and treatment process for minors (Coleman, et al., 2022; Hembree, et al., 2017).

71. Similar to GnRHa, the risks and benefits of hormone treatment are discussed with patients (and families, if the patient is a minor) prior to initiation of testosterone or estrogen. When treated with testosterone or estrogen, the goal is to maintain the patient's hormone levels within the normal range for their gender. Laboratory testing is recommended to ensure proper dosing and hormonal levels. If starting hormonal care after completing puberty, discussion of egg or sperm preservation prior to starting treatment is recommended.

72. Regardless of the treatment plan prescribed, at every encounter with the care team there is a re-evaluation of the patient's gender identity and their transition goals. Should a patient desire to discontinue a medical intervention, the intervention is discontinued. Discontinuation of GnRHa will result in commencement of puberty. Findings from studies in which participants have undergone comprehensive evaluation prior to gender care show low levels of regret (de Vries, et al., 2011; van der Loos, et al., 2022; Wiepjes, et al., 2018).

73. Surgical interventions, including but not limited to chest and genital surgery, are indicated in appropriately selected patients. These surgeries are not typically performed in adolescence but rather considered in adulthood. Surgical care is not addressed in this case. The WPATH SOC 8 outlines the current literature supporting benefits of surgical interventions for patients with gender dysphoria (Coleman, et al., 2022).

F. SAFETY AND EFFICACY OF PUBERTY-DELAYING MEDICATIONS AND HORMONE THERAPY TO TREAT GENDER DYSPHORIA

74. GnRHa, prescribed for delaying puberty in transgender adolescents, is both a safe and effective treatment. Patients under consideration for treatment are working within a multidisciplinary team of providers all dedicated to making informed and appropriate decisions with the patient and family in the best interest of the adolescent. Physicians providing this intervention are trained and qualified in gender

identity concerns and childhood growth and development and are participating in this care out of a desire to improve the health and wellness of transgender youth and prevent negative outcomes such as depression and suicide.

75. GnRHa, including injectable leuprolide and implantable histrelin, have rare side effects which are discussed with patients and families prior to initiation. Mild negative effects may include pain at the injection or implantation site, sterile abscess formation, weight gain, hot flashes, abdominal pain, and headaches. These effects can be seen in patients receiving GnRHa for gender dysphoria, or for other indications such as precocious puberty. I counsel patients on maintaining a healthy diet and promote physical activity, and regularly document height and weight during treatment. Nutritional support can be provided for patients at risk for obesity.

76. Risk of lower bone mineral density in prolonged use of GnRHa can be mitigated by screening for, and treating, vitamin D deficiency when present, and by limiting the number of years of treatment based on a patient's clinical course (Rosenthal, 2014). An exceptionally rare but significant side effect, increased intracranial pressure, has been reported in six patients (five treated for precocious puberty, one for transgender care), prompting an FDA warning in July 2022 (AAP, 2022). These cases represent an extremely small fraction of the thousands of patients who have been treated with GnRHa over decades. Symptoms of this side effect (headache, vomiting, visual changes) are reviewed with families and if they occur the

medication is discontinued.

77. GnRHa do not have long-term implications on fertility. This is clearly proven from decades of use in the treatment of precocious puberty (Guaraldi, et al., 2016; Martinerie, et al, 2021). Progression through natal puberty is required for maturation of egg or sperm. If attempting fertility after previous treatment with GnRHa followed by hormone therapy is desired, an adult patient would withdraw from hormones and allow pubertal progression. Assistive reproduction could be employed if needed (T'Sjoen, et al., 2013).

78. Patients who initiate hormones after completing puberty are offered gamete preservation prior to hormonal initiation (Coleman, et al., 2022), but even when not undertaken, withdrawal of hormones in adulthood often is successful in achieving fertility when it is desired (Light, et al., 2014; Knudson, et al., 2017).

79. Discussing the topic of fertility is important, and not specifically unique to treatment of gender dysphoria. Medications used for other medical conditions, such as chemotherapeutics used in cancer treatment, can affect fertility. For all medications with potential impacts on fertility, the potential risks and benefits of both treatment and non-treatment should be reviewed and data regarding risk for infertility clearly articulated prior to the consent or assent of the patient. Risk for fertility changes must be balanced with the risk of withholding treatment.

80. Review of relevant medical literature clearly supports the benefits of

GnRHa treatment on both short-term and long-term psychological functioning and quality of life (e.g., Achille, et al., 2020; Carmichael, et al., 2021; Costa, et al., 2015; de Vries, et al., 2014; de Vries, et al., 2011; Kuper, et al., 2020; Turban, et al., 2020b; van der Miesen, et al., 2020). For example, a 2014 long-term follow-up study following patients from early adolescence through young adulthood showed that gender-affirming treatment allowed transgender adolescents to make age-appropriate developmental transitions while living as their affirmed gender with positive outcomes as young adults (de Vries, et al., 2014).

81. In my own practice, adolescent patients struggling with significant distress at the onset of puberty routinely have dramatic improvements in mood, school performance, and quality of life with appropriate use of GnRHa. Side effects encountered are similar to those seen in other patients treated with these medications and easily managed.

82. Hormone therapy (testosterone or estrogen) is prescribed to older adolescents with gender dysphoria. As is the case with GnRHa, the need for hormone therapy is not unique to transgender adolescents. Patients with conditions such as delayed puberty, hypogonadism, Turner Syndrome, Klinefelter Syndrome, agonism, premature ovarian failure, and disorders of sex development all require treatment with these hormones, often starting in adolescence and continuing lifelong. Without testosterone or estrogen treatment, these patients would be unable to progress through

puberty normally, which would have serious medical and social consequences. Whether used in adolescents to treat gender dysphoria, or to treat any of these other conditions, testosterone and estrogen are prescribed with a goal to raise the testosterone or estrogen level into the normal male or female range for the patient's age. Careful monitoring of blood levels and clinical progress are required. Side effects are rare, but most often related to overtreatment, which can be minimized with this monitoring. Additionally, side effects are considered, discussed, and easily managed in all individuals needing hormone therapy regardless of the diagnosis necessitating these medications.

83. Venous thromboembolism (blood clotting) is a known side effect of estrogen therapy in all individuals placed on it including transgender women. Risk is increased in old age, in patients with cancer, and in patients who smoke nicotine. This side effect is mitigated by careful and accurate prescribing and monitoring. In my career, no patient has suffered a thromboembolism while on estrogen therapy.

84. Treatment of gender dysphoria with testosterone or estrogen is highly beneficial for both short-term and long-term psychological functioning of adolescents with gender dysphoria and withholding treatment from those who need it is harmful (e.g., Achille, et al., 2020; Allen, et al., 2019; Chen, et al., 2023; de Lara, et al., 2020; de Vries, et al., 2014; Grannis, et al., 2021; Green, et al., 2022; Kaltiala, et al., 2020; Kuper, et al., 2020). To highlight examples, Green et al. (2022) describe that gender-

affirming hormone therapy is correlated with reduced rates of depression and suicidality among transgender adolescents. Turban et al. (2022) documented that access to gender-affirming hormone therapy in adolescence is associated with favorable mental health outcomes in adulthood, when compared to individuals who desired but could not access hormonal interventions.

85. I treat many patients with gender dysphoria GnRHa, testosterone, and estrogen. Side effects related to these medications are very rare and can be treated with dose adjustment and/or lifestyle changes.

86. In sum, the use of GnRHa and hormones in adolescents for the treatment of gender dysphoria is the current standard of care and certainly not experimental. This is due to robust evidence of safety and efficacy. The sum of the data supports the conclusion that treatment of gender dysphoria with these interventions promotes wellness and helps to prevent negative mental health outcomes, including suicidality in adolescents. The data to support these interventions are so strong that withholding such interventions would be negligent and unethical.

G. HARMS ASSOCIATED WITH PROHIBITING AND DISCONTINUING TREATMENT

87. Prohibition of gender-affirming care for adolescents is likely to have devastating consequences. I am concerned such a prohibition might lead to a staggering increase in mental health problems including suicidality for transgender children and adolescents in Kentucky. One study which highlights my concern is a

study of over 21,000 patients who report ever desiring gender-affirming hormone care. When comparing those who were able to access this care to those desiring but never accessing care, those able to access care had lower odds of suicidality within the past year. In addition, those individuals where were able to access care in adolescence had lower odds of suicidality compared to those waiting to access until adulthood (Turban, et al., 2022).

88. Even more concerning is a situation where patients currently receiving care and thriving would be forced to discontinue this care.

III. CONCLUSION

89. In summary, banning gender-affirming care for adolescent children runs counter to evidence-based best practices and standards of care for the treatment of gender dysphoria.

90. Gender dysphoria is a challenging condition, but it is treatable through individualized assessment and treatment, which may include social transition, psychotherapy, pubertal suppression, and hormonal therapy. These treatments are not experimental and are supported by all major medical bodies in the field of transgender medicine and pediatrics.

91. Lack of access to these treatments will result in worse outcomes for countless youth in Kentucky. Furthermore, banning evidence-based treatment for gender dysphoria sends a message that transgender youth are not valid and should be

stigmatized.

92. In my own clinical practice in Michigan, I have seen an influx of patients from states banning medically proven treatments for gender dysphoria who report not feeling safe living in the community that they have always called home. Parents who love and support their transgender children have described themselves as "refugees" in their own country, moving to avoid discriminatory laws which they know would clearly harm their health or the health of their child.

93. Banning effective treatment for gender dysphoria will not eliminate transgender youth, but will, unfortunately, lead to an increase in mental health problems and suicidality in an already vulnerable population.

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

Executed this 15th day of May 2023.

Daniel Shumer, M.D.

Exhibit A

Curriculum Vitae

Daniel Shumer, MD MPH

Clinical Associate Professor in Pediatrics - Endocrinology

Email: dshumer@umich.edu

EDUCATION AND TRAINING

Education

08/2000-08/2003	BA, Northwestern University, Evanston, United States
08/2004-05/2008	MD, Northwestern University, Feinberg School of Medicine, Chicago, United States
07/2013-05/2015	MPH, Harvard T.H. Chan School of Public Health, Boston, United States

Postdoctoral Training

06/2008-06/2011	Residency, Pediatrics, Vermont Children's Hospital at Fletcher Allen Health Care, Burlington, VT
07/2011-06/2012	Chief Resident, Chief Resident, Vermont Children's Hospital at Fletcher Allen Health Care, Burlington, VT
07/2012-06/2015	Clinical Fellow, Pediatric Endocrinology, Boston Children's Hospital, Boston, MA

CERTIFICATION AND LICENSURE

Certification

10/2011-Present	American Board of Pediatrics, General

Licensure

	Michigan, Medical License
	Michigan, Controlled Substance
08/2015-Present	Michigan, Medical License

09/2015-Present Michigan, DEA Registration

09/2015-Present Michigan, Controlled Substance

WORK EXPERIENCE

Academic Appointment

10/2015-9/2022 Clinical Assistant Professor in Pediatrics - Endocrinology, University of Michigan - Ann Arbor, Ann Arbor

09/2022-Present Clinical Associate Professor in Pediatrics - Endocrinology, University of Michigan - Ann Arbor, Ann Arbor

Administrative Appointment

07/2019-Present Fellowship Director - Pediatric Endocrinology, Michigan Medicine, Department of Pediatrics, Ann Arbor

07/2020-Present Medical Director of the University of Michigan Comprehensive Gender Services Program, Michigan Medicine, Ann Arbor

Oversee the provision of care to transgender and gender non-conforming patients at Michigan Medicine.

07/2020-Present Education Lead - Pediatric Endocrinology, University of Michigan - Department of Pediatrics, Ann Arbor

Clinical Appointments

04/2022-05/2023 Medical Director in UMMG Faculty Benefits Appt., University of Michigan - Ann Arbor, Ann Arbor

Private Practice

08/2013-09/2015 Staff Physician, Harvard Vanguard Medical Associates, Braintree

RESEARCH INTERESTS

- Gender dysphoria
- Prader Willi Syndrome

CLINICAL INTERESTS

- Gender dysphoria
- Disorders of Sex Development
- Prader Willi Syndrome

GRANTS

Past Grants

A Phase 2b/3 study to evaluate the safety, tolerability, and effects of Livoletide (AZP-531), an unacylated ghrelin analog, on food-related behaviors in patients with Prader-Willi syndrome
PI
Millendo Therapeutics
04/2019 - 04/2021

HONORS AND AWARDS

National

2014	Annual Pediatric Endocrine Society Essay Competition: Ethical Dilemmas in Pediatric Endocrinology: competition winner - The Role of Assent in the Treatment of Transgender Adolescents

Institutional

2012 - 2015	Harvard Pediatric Health Services Research Fellowship; funded my final two years of pediatric endocrine fellowship and provided tuition support for my public health degree

2016	The University of Michigan Distinguished Diversity Leaders Award, awarded by The Office of Diversity, Equity and Inclusion to the Child and Adolescent Gender Services Team under my leadership
2019	Lecturer of the Month, Department of Pediatrics, Michigan Medicine

TEACHING MENTORSHIP

Resident

07/2020-Present	Rebecca Warwick, Michigan Medicine (co-author on publication #22)

Clinical Fellow

07/2017-06/2020	Adrian Araya, Michigan Medicine (co-author on publication #22, book chapter #4)
12/2020-Present	Jessica Jary, Michigan Medicine - Division of Adolescent Medicine

Medical Student

09/2017-06/2020	Michael Ho, Michigan Medicine
07/2019-Present	Hadrian Kinnear, University of Michigan Medical School (co-author on book chapter #3, abstract #3)
07/2019-Present	Jourdin Batchelor, University of Michigan

TEACHING ACTIVITY

Regional

08/2018-Present	Pediatric Boards Review Course sponsored by U-M: "Thyroid Disorders and Diabetes". Ann Arbor, MI

Institutional

12/2015-12/2015	Pediatric Grand Rounds: "Transgender Medicine - A Field in Transition". Michigan Medicine, Ann Arbor, MI
02/2016-02/2016	Medical Student Education: Panelist for M1 Class Session on LGBT Health, Doctoring Curriculum. Michigan Medicine, Ann Arbor, MI
02/2016-02/2016	Psychiatry Grand Rounds: "Transgender Medicine - A Field in Transition". Michigan Medicine, Ann Arbor, MI
03/2016-03/2017	Pharmacy School Education: "LGBT Health". University of Michigan School of Pharmacy, Ann Arbor, MI
04/2016-Present	Course Director: Medical Student (M4) Elective in Transgender Medicine. Michigan Medicine, Ann Arbor, MI
04/2016-04/2016	Rheumatology Grand Rounds: "Gender Identity". Michigan Medicine, Ann Arbor, MI
05/2016-05/2016	Lecture to Pediatric Rheumatology Division: "Gender Dysphoria". Michigan Medicine, Ann Arbor, MI
07/2016-07/2016	Internal Medicine Resident Education: "Gender Identity". Michigan Medicine, Ann Arbor, MI
09/2016-09/2016	Presentation to ACU Leadership: "Gender Identity Cultural Competencies". Michigan Medicine, Ann Arbor, MI
10/2016-10/2016	Presentation to Department of Dermatology: "The iPledge Program and Transgender Patients". Michigan Medicine, Ann Arbor, MI
02/2017-02/2017	Swartz Rounds Presenter. Michigan Medicine, Ann Arbor, MI
02/2017-02/2017	Lecture to Division of General Medicine: "Transgender Health". Michigan Medicine, Ann Arbor, MI

02/2017-02/2017	Presentation at Collaborative Office Rounds: "Transgender Health". Michigan Medicine, Ann Arbor, MI
10/2017-10/2017	Family Medicine Annual Conference: "Transgender Medicine". Michigan Medicine, Ann Arbor, MI
12/2017-12/2017	Presenter at Nursing Unit 12-West Annual Educational Retreat: "Gender Identity at the Children's Hospital". Michigan Medicine, Ann Arbor, MI
02/2018-Present	Pediatrics Residency Lecturer: "Puberty". Michigan Medicine, Ann Arbor, MI
02/2019-Present	Medical Student (M1) Lecturer: "Pediatric Growth and Development". Michigan Medicine, Ann Arbor, MI
02/2019-Present	Doctors of Tomorrow Preceptor: offering shadowing opportunities to students from Cass Technical High School in Detroit. Michigan Medicine, Ann Arbor, MI
03/2019-03/2019	Lecture to Division of Orthopedic Surgery: "Transgender Health". Michigan Medicine, Ann Arbor, MI

MEMBERSHIPS IN PROFESSIONAL SOCIETIES

2012 - Present	Pediatric Endocrine Society

COMMITTEE SERVICE

National

2014 - 2016	Pediatric Endocrine Society - Ethics Committee, Other, Member
2017 - present	Pediatric Endocrine Society - Special Interest Group on Gender Identity, Other, Member
2018 - present	Pediatric Endocrine Society - Program Directors Education Committee, Other, Member

Regional

2013 - 2015 Investigational Review Board - The Fenway Institute, Boston, MA, Other, Voting Member

Institutional

2017 - 2019 Department of Pediatrics at Michigan Medicine; Diversity, Equity, and Inclusion Committee, Other, Fellowship Lead

2017 - 2019 University of Michigan Transgender Research Group, Other, Director

VOLUNTEER SERVICE

2014 Camp Physician, Massachusetts, Served at a camp for youth with Type 1 Diabetes

SCHOLARLY ACTIVITIES

PRESENTATIONS

Extramural Invited Presentation Speaker

1. Grand Rounds, Shumer D, Loyola University School of Medicine, 07/2022, Chicago, Illinois

Other

1. Gender Identity, Groton School, 04/2015, Groton, MA

2. Television Appearance: Gender Identity in Youth, Channel 7 WXYZ Detroit, 04/2016, Southfield, MI

3. It Gets Better: Promoting Safe and Supportive Healthcare Environments for Sexual Minority and Gender Non-Conforming Youth, Adolescent Health Initiative: Conference on Adolescent Health, 05/2016, Ypsilanti, MI

4. Gender Identity, Humanists of Southeast Michigan, 09/2016, Farmington Hills, MI

5. Gender Identity, Pine Rest Christian Mental Health Services, 10/2016, Grand Rapids, MI

6. Pediatric Grand Rounds - Hormonal Management of Transgender Youth, Beaumont Children's Hospital, 11/2016, Royal Oak, MI

7. Transgender Youth: A Field in Transition, Temple Beth Emeth, 11/2016, Ann Arbor, MI

8. Transgender Youth: A Field in Transition, Washtenaw County Medical Society, 11/2016, Ann Arbor, MI

9. Pediatric Grand Rounds: Transgender Youth - A Field in Transition, St. John Hospital, 02/2017, Detroit, MI

10. Transgender Medicine, Veterans Administration - Ann Arbor Healthcare System, 05/2017, Ann Arbor, MI

11. Gender Identity, Hegira Programs, 05/2017, Detroit, MI

12. Care of the Transgender Adolescent, Partners in Pediatric Care, 06/2017, Traverse City, MI

13. Conference planner, host, and presenter: Transgender and Gender Non-Conforming Youth: Best Practices for Mental Health Clinicians, Educators, & School Staff; 200+ attendees from fields of mental health and education from across Michigan, Michigan Medicine, 10/2017, Ypsilanti, MI

14. Endocrinology Grand Rounds: Transgender Medicine, Wayne State University, 11/2017, Detroit, MI

15. Care of the Transgender Adolescent, St. John Hospital Conference: Transgender Patients: Providing Compassionate, Affirmative and Evidence Based Care, 11/2017, Grosse Pointe Farms, MI

16. Hormonal Care in Transgender Adolescents, Michigan State University School of Osteopathic Medicine, 11/2017, East Lansing, MI

17. Working with Transgender and Gender Non-Conforming Youth, Michigan Association of Osteopathic Family Physicians, 01/2018, Bellaire, MI

18. Community Conversations, Lake Orion, 01/2018, Lake Orion, MI

19. "I Am Jazz" Reading and Discussion, St. James Episcopal Church, 03/2019, Dexter, MI

20. Gender Identity, Michigan Organization on Adolescent Sexual Health, 10/2019, Brighton, MI; Port Huron, MI

21. Ask The Expert, Stand With Trans, 05/2020, Farmington Hills, MI (Virtual due to COVID)

22. Transgender Medicine, Michigan Association of Clinical Endocrinologists Annual Symposium, 10/2020, Grand Rapids, MI (Virtual due to COVID)

23. Transgender Youth in Primary Care, Michigan Child Care Collaborative (MC3), 10/2020, Ann Arbor, MI (Virtual due to COVID)

24. Lets Talk About Hormones, Stand With Trans, 10/2020, Farmington Hills, MI (Virtual due to COVID)

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Exhibit B

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY

JANE DOE 1, et al., *Plaintiffs*, v. WILLIAM C. THORNBURY, JR., MD, et al., *Defendants*.	Civil No. 3:23-cv-00230-DJH

DECLARATION OF ARON JANSSEN, M.D.

1. My name is Aron Janssen, M.D. I am a board-certified child and adolescent psychiatrist. I specialize in the treatment of gender dysphoria in children and adolescents. I have been retained by counsel for Plaintiffs in the above-captioned lawsuit to provide an expert opinion on the standards of care for treating individuals diagnosed with gender dysphoria.

Background and Qualifications

2. The information provided regarding my professional background, experiences, publications, and presentations are detailed in my curriculum vitae. A true and correct copy of my CV is attached as Exhibit A.

3. I received my medical degree from the University of Colorado School

of Medicine. I completed my residency in psychiatry and a fellowship in child and adolescent psychiatry at New York University Langone Medical Center.

4. In 2011, I founded the Gender and Sexuality Service at New York University, a clinical service dedicated to treating children and adolescents with gender dysphoria. In my last five years at NYU, that clinic served over 200 families, with 2-3 new referrals each week.

5. I am currently the Vice Chair of the Pritzker Department of Psychiatry and Behavioral Health and Chief Psychiatrist for the Gender Development Program at Ann and Robert H. Lurie Children's Hospital of Chicago. I am also a Clinical Associate Professor of Child and Adolescent Psychiatry at Northwestern University Feinberg School of Medicine. I maintain a clinical practice in Illinois where I treat patients from Illinois and the surrounding states.

6. I have been treating children and adolescents with gender dysphoria for over 10 years. I have treated over 300 children and adolescents with gender dysphoria during my medical career. Currently, approximately 90 percent of the patients in my clinical practice are transgender children and adolescents.

7. I am a contributing author to the Child and Adult Mental Health chapters of the Eighth Version of the World Professional Association for Transgender Health's (WPATH) *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8* (hereafter, "WPATH SOC").

8. The WPATH SOC provides clinical guidance for health professionals based on the best available science and expert professional consensus. The purpose of the WPATH SOC is to assist health providers in delivering necessary and appropriate medical care to transgender and gender diverse people, in order to maximize their patients' overall health, psychological well-being, and self-fulfillment. The WPATH SOC has been recognized and adopted as the prevailing standard of care by the major professional associations 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, among others.

9. In addition, I have written a number of peer-reviewed journal articles and chapters in professional textbooks about treatment of gender dysphoria in children and adolescents. In 2018, I co-edited *Affirmative Mental Health Care for Transgender and Gender Diverse Youth: A Clinical Casebook*, which is the first published clinical casebook on mental health treatment for children and adolescents with gender dysphoria. A full and complete list of my publications is included in my CV.

10. I am an Associate Editor for the journal *Transgender Health*, and an Ad Hoc Reviewer for the journal *LGBT Health*. Each of these publications is a peer-reviewed medical journal.

11. I am actively involved in training other medical and mental health providers in the treatment of children and adolescents with gender dysphoria. I have conducted trainings for over 1,000 medical and mental health providers and have given dozens of public addresses, seminars, and lectures on the treatment of gender dysphoria in children and adolescents. I have also taught a number of courses through WPATH's Global Education Initiative, which provides training courses toward a member certification program in transgender health for practitioners around the world.

12. I am a member of the following professional organizations: American Psychiatric Association, American Academy of Child and Adolescent Psychiatry (AACAP), and World Professional Association for Transgender Health (WPATH). I am also a co-chair of the Sexual Orientation and Gender Identity Committee of AACAP and have participated in the Gender Dysphoria Working Group of the American Psychiatric Association, and the Transgender Health Committee of the Association of Gay and Lesbian Psychiatrists.

13. I am being compensated at an hourly rate of $400/hour plus expenses for my time spent in connection with this case. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

14. In the previous four years, I was retained as an expert witness by the

plaintiffs and deposed in *B.P.J. v. West Virginia State Board of Education* et al., No. 2:21-cv-00316 (S.D.W.V.), and *L.E. v. Lee* et al, No. 3.21-cv-00835 (M.D. Tenn).

Basis for Opinions

15. My opinions contained in this declaration are based on: (1) my clinical experience as a psychiatrist treating transgender patients, including adolescents and young adults; (2) 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; (3) my work as a contributing author of the WPATH SOC; and (4) my review of the law challenged in this case. In preparing this declaration, I have also reviewed the materials listed in the attached bibliography, Exhibit B. The sources cited therein are authoritative, scientific peer-reviewed publications. These are the same types of materials that experts in my field of study regularly rely upon when formulating opinions on the subject. I reserve the right to revise and supplement the opinions expressed in this declaration or the bases for them if any new information becomes available in the future, including as a result of new scientific research or publications or in response to statements or issues that may arise in my area of expertise.

Discussion

Gender Identity Development and Gender Dysphoria in Children and Adolescents

16. At birth, infants are assigned a sex, either male or female, based on the

appearance of their external genitalia. For most people, their sex assigned at birth, or assigned sex, matches that person's gender identity. For transgender people, their assigned sex does not align with their gender identity.

17. Gender identity is a person's innate sense of their gender. It is a core and universal component of human identity.

18. It is essential to a person's mental health and well-being to be able to live consistent with their gender identity. This is true for transgender and non-transgender people.

19. Gender identity has a biological basis and cannot be altered through medical or psychological interventions.

20. The evidence demonstrating that gender identity cannot be altered, either for transgender or for non-transgender individuals, underscores the innate nature of gender identity. Past attempts to "cure" transgender individuals by using talk therapy, and even aversive therapy, to change their gender identity to match their birth-assigned sex were ineffective and caused harm. The major associations of medical and mental health providers, such as the American Medical Association, the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, the American Psychological Association, and WPATH's standards of care, consider such efforts harmful and unethical.

21. Gender dysphoria is the medical diagnosis for the severe and

unremitting psychological distress resulting from the incongruity between a transgender person's assigned sex and their gender identity. That distress can be alleviated when a transgender person is able to live consistent with their gender identity.

22. It is a serious medical condition and is listed in the Diagnostic and Statistical Manual, Version 5 (DSM-5), the diagnostic and coding compendium for mental health professionals.

Standard of Care for Treatment of Gender Dysphoria in Youth

23. Like all children, transgender children can thrive, grow into healthy adults, and have the same capacity for happiness, achievement, and contribution to society as others. For this group of young people, that means supporting their need to live in a manner consistent with their gender identity in all aspects of their lives.

24. Accordingly, the goal of treatment for gender dysphoria is to reduce distress and improve functioning which often occurs through the process of enabling the individual to live consistent with their gender identity. The process of undergoing those treatments is often referred to as gender transition. The stages that make up a transgender person's gender transition will depend on that individual's medical and mental health needs. The purpose of transition is to allow a transgender person to live congruently with their gender identity, including in many cases undergoing medical treatments to align the person's body with who they are.

25. Typically, transgender people start their transition with a series of steps that are commonly referred to as a "social transition." Those steps include, but are not limited to, changing their name, using different pronouns, wearing clothing and adopting grooming habits typically associated with their gender identity. Making those changes enable a transgender person to begin living their life consistent with their gender identity and helps ensure that they are treated as such by family, peers, and others in the community. It is important to note that there are no medical interventions for pre-pubertal transgender children. For some children, social transition is an appropriate intervention, while for others, treatment for gender dysphoria may involve but not be limited to building family and social support or building resilience.

26. After the onset of puberty, transgender young people may also start taking puberty-delaying medication to prevent the development of unwanted and psychologically distressing secondary-sex characteristics that conflict with the person's identity.

27. Gender affirming hormone therapy is medically necessary for some transgender young people regardless of whether they have taken puberty-delaying medication. That treatment causes their bodies to develop the secondary-sex characteristics more aligned with their gender identity, such as facial and body hair for boys who are transgender and female breast development in girls who are

transgender.

28. Delaying any of these treatments, including puberty blockers or hormone therapy, when determined to be medically necessary will not only exacerbate a transgender young person's gender dysphoria, but also could lead to the development of other co-occurring mental health conditions, including depression, anxiety, and disordered eating. Those co-occurring mental health conditions may be accompanied by unhealthy coping behaviors such as self-harm, substance misuse, and suicide attempts.

Safe and Effective Treatments for Gender Dysphoria

29. Research and clinical experience repeatedly reaffirm that gender transition significantly improves the mental and physical health of transgender young people and is the only treatment that has been demonstrably effective for gender dysphoria.

30. This is true of each stage of a transgender young person's gender 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).

31. Gender 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 are often able to reduce dosage of psychiatric medications and 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. For example, a recent study found that after two years of hormone treatment, transgender youth experienced increases in positive affect and life satisfaction and decreases in depression and anxiety symptoms. Diane Chen, et al., *Psychosocial Functioning in Transgender Youth after Two Years of Hormones,* 388 N. Engl. J. Med. 240 (2023).

32. Research shows that gender transition significantly improves the mental health of transgender young people, bringing their mental health profiles into alignment with their non-transgender peers. Kristina Olson, et al., *Mental health of transgender children who are supported in their identities*, 137 Pediatrics 1 (2016);[1]

[1] Anxiety was the only area where transgender young people differed from

see also Jack Turban, et al., *Pubertal suppression for transgender youth and risk of suicidal ideation*, 145 Pediatrics 1 (2020) (transgender people who accessed puberty suppression treatment were 70% less likely to contemplate suicide).

33. Well-established research demonstrates the effectiveness of gender transition as treatment for gender dysphoria in adolescence. Jack Turban, Annelou DeVries & Kenneth Zucker, *Gender Incongruence & Gender Dysphoria*, in *Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook*, (A Martin, et al., eds., 5th ed., 2018).

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

34. The first objective of a mental health provider treating a child or adolescent who appears to be experiencing gender dysphoria is to conduct a careful and thorough assessment. That assessment allows the provider to accurately diagnose the patient, including whether the patient meets the stringent criteria for gender dysphoria and any co-occurring conditions. The foundation of the assessment process is building a detailed history of the patient, such as prior treatment, trauma, substance misuse, among many other factors. That assessment also requires a developmentally informed exploration of the patient's relationship to their gender identity over time that includes information obtained from multiple informants

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the non-transgender controls. On that measure, transgender young people showed slightly elevated levels of anxiety, but were still in the pre-clinical range.

whenever possible.

35. 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 depending on the patient's presentation and the complexity of the issues the patient is navigating. The assessment process also goes beyond gathering information from the patient and their family. The mental health provider will typically gather and review information from the patient's primary care provider, prior mental health providers, and other adult professionals who are part of the patient's care team.

36. A detailed history and assessment are important to provide the context for developing an appropriate treatment plan. That comprehensive assessment is also needed to help inform possible future care plans, such as the patient's need for puberty blockers or hormone therapy. Once this treatment plan is developed, the mental health provider remains involved in the treatment plan, ensuring that the plan continues to address the patient's individual needs. For example, mental health providers regularly assess the effects of gender dysphoria on a patient's life and functioning. The purpose of that ongoing evaluation is to identify the areas where the patient needs to develop resilience and coping strategies to minimize the effects

of their gender dysphoria and to evaluate the mental health benefits of future treatment options.

37. Because of the thoroughness of this process, an assessment to determine the necessity of medical treatments typically occurs over several months. For patients who begin care as children, the assessment is based on years' worth of information.

38. A critical element of the standard of care is that it does not presume that being transgender is incompatible with a young person's short- and long-term health and well-being. That is consistent with DSM-5 diagnostic criteria which is "focus[ed] on dysphoria as the clinical problem, not identity per se." American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, 451 (2013). As a result, therapists practicing consistent with the standard of care will create a space where the patient can explore their gender identity, knowing that being transgender and not being transgender are both equally acceptable outcomes.[2]

[2] As observed in the context of research on gender identity conversion efforts and family rejection, attempting to influence a young person's gender identity development is harmful, ineffective, and unethical. For example, a recent study found that being exposed to gender identity conversion efforts was associated with greater odds of attempting suicide, especially for those had those experiences in childhood. Jack Turban, et al., *Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults*, 77 JAMA Psychiatry 68 (2020).

39. Providing that individualized mental health treatment means that mental health providers are not simply a rubber-stamp in the process for accessing treatment for gender dysphoria. Instead, as is the case with all effective mental health treatment, the focus of the treatment is supporting overall health and well-being, regardless of whether the young person continues to identify as transgender. As a result, I have had patients who presented with some symptoms of gender dysphoria, but who ultimately did not meet the diagnostic criteria for a variety of reasons, and therefore I recommended treatments other than transition to alleviate their psychological distress. My experience in working with and speaking with other gender specialists is that this is routine throughout the profession. Part of the rigor of the diagnostic protocol is distinguishing between youth who are engaged in gender exploration from youth who are transgender and who do or will need treatment for gender dysphoria.

40. For young people who do meet the diagnostic criteria for gender dysphoria, mental health treatment often involves referring a patient for medical treatments. That process involves an assessment of the patient's gender dysphoria, co-occurring conditions, and the medical treatment's likely effect on the patient's overall mental health and functioning. As part of that process, mental health providers also discuss the risks, benefits, and alternatives to treatment with transgender young people and their parents.

41. A patient's readiness to begin a particular course of medical treatment requires an evaluation of the patient's and the parent's/caregiver'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 is explored over multiple meetings with the patient and parents. 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.

42. 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. Ultimately, the appropriateness of any medical treatment is determined by a multidisciplinary team of expert mental and medical care providers.

Assessing Co-Occurring Conditions & Necessity of Medical Treatment for Gender Dysphoria

43. The existence—and prevalence—of co-occurring conditions among transgender young people is unsurprising. Transgender young people must cope with many stressors from the fear of rejection from family and peers to pervasive societal discrimination. In addition, their underlying gender dysphoria can cause significant psychological distress, which, if left untreated, can result in the development of co-occurring conditions.

44. Transgender young people, however, are not outliers in this regard. Research and clinical experience show that most psychiatric conditions are highly correlated with other co-occurring psychiatric conditions. For example, young people with depression are very likely to have at least one other diagnosable condition, most often anxiety. *See, e.g.*, E. Jane Costello, et al., *Prevalence and development of psychiatric disorders in childhood and adolescence*, 60 Archives of Gen. Psychiatry 837 (2003) ("There was strong heterotypic continuity from depression to anxiety" and finding approximately 30% of participants diagnosed with a depressive disorder were also diagnosed with an anxiety disorder). Likewise, a study on children diagnosed with Attention-Deficit/Hyperactivity Disorder found between 74-79% participants had additional co-occurring psychiatric conditions. Timothy Wilens, et al., *Psychiatric Comorbidity and Functioning in Clinically Referred Preschool Children and School-Age Youths With ADHD*, 41 J. of Am.

Academy of Child & Adol. Psychiatry 262 (2002).

45. A comprehensive assessment—the cornerstone of the prevailing standards of care for the treatment of gender dysphoria—not only seeks to identify any co-occurring conditions, but also to evaluate the effect those conditions have on a transgender person's functioning. This is equally true when assessing whether medical treatment for gender dysphoria is necessary from a mental health perspective.

46. The standards of care recognize that it is not possible for a transgender patient to resolve all co-occurring conditions prior to undergoing medical treatment, nor would it be ethical to impose such a requirement. Resolving all co-occurring conditions before medical treatment is not a requirement for other conditions. Gender dysphoria, by definition, is accompanied by clinically significant psychological distress. That distress can take on many different forms (*e.g.*, anxiety, mood disorders, and depression) and vary greatly in severity, resulting in co-occurring conditions. Because psychological distress is not easily compartmentalized, the distress associated with gender dysphoria can also amplify co-occurring conditions that developed independently of the gender dysphoria. In either situation, gender dysphoria limits the effectiveness of treatment of any co-occurring mental health conditions. Thus, treating the underlying gender dysphoria is essential to alleviating the psychological distress associated with co-occurring

conditions.

47. Even assuming that it was possible to cure a patient's co-occurring conditions, delaying medical treatment can cause very real harms to a transgender person's physical and mental health. Without medical treatment, their gender dysphoria would continue to persist and often worsen. At a minimum, that increased distress would interfere with the treatment for the person's co-occurring conditions, subjecting them unnecessarily to a longer course of treatment. It is often seen that the gender dysphoria would eclipse the person's co-occurring conditions, not only entirely impeding treatment of those co-occurring conditions, but also resulting in an overall deterioration of their mental health. The increased distress from their gender dysphoria would translate to resorting to negative coping mechanisms (*i.e.*, self-harm), suicidal ideation, and suicide attempts—just as it could if that increased distress was attributable to a co-occurring condition.

48. Gender dysphoria is a real and serious medical condition that is highly treatable. There is a rigorous and comprehensive protocol for diagnosing an individual with the condition. There is also a well-established standard of care for the treatment of gender dysphoria, including for treatment of gender dysphoria in transgender youth with puberty blockers and hormone therapy. When that treatment is provided, transgender youth can thrive. There are studies that have demonstrated that, and my own experience confirms it. In my experience, I have seen mental health

providers carefully assess and work with youth, their parents, and other doctors that care for the youth to create a treatment plan that includes continuing mental health care and ongoing assessments.

49. Medical treatment for gender dysphoria has immense psychological benefits for youth, bringing their mental health to a level similar to their non-transgender peers. My understanding is that the law challenged in this case will prevent transgender youth in Kentucky who are diagnosed with gender dysphoria from getting essential medical care that they need. In my professional opinion, if transgender youth cannot get the medical care that they need, including puberty blockers and hormone therapy, they will suffer and their mental health will deteriorate.

50. I hold each of the opinions expressed in this declaration with a reasonable degree of scientific certainty, based on the materials I have reviewed and on my education, experience, and knowledge. I reserve the right to supplement, amend, or modify my opinions upon review of further information, including, but not limited to, testimony, documents, and reports I receive after the date of this declaration.

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

Executed this 15th day of May 2023.

Aron Janssen, M.D.

Exhibit A

Curriculum Vitae

Curriculum Vitae

Aron Janssen, M.D.

Personal Data

Born	Papillion, Nebraska
Citizenship	USA

Academic Appointments

2011-2017	Clinical Assistant Professor of Child and Adolescent Psychiatry
2011-2019	Founder & Clinical Director, NYU Gender and Sexuality Service Director, LGBT Mental Health Elective, NYULMC
2015-2019	Co-Director, NYU Pediatric Consultation Liaison Service New York University Department of Child and Adolescent Psychiatry
2017-present	Clinical Associate Professor of Child and Adolescent Psychiatry
2019-present	Vice Chair, Pritzker Department of Psychiatry and Behavioral Health Ann and Robert H. Lurie Children's Hospital of Chicago
2020-present	Medical Director, Outpatient Psychiatric Services Ann and Robert H. Lurie Children's Hospital of Chicago

Education

Year	Degree	Field	Institution
6/97	Diploma		Liberty High School
5/01	B.A.	Biochemistry	University of Colorado
5/06	M.D.	Medicine	University of Colorado

Postdoctoral Training

2006-2009	Psychiatry Residency	Ze'ev Levin, M.D.	NYU Department of Psychiatry
2009-2011	Child and Adolescent Psychiatry Fellowship – Fellow and Clinical Instructor		
		Jess Shatkin, M.D.	NYU Dept of Child/Adolescent Psychiatry

Licensure and Certification

2007-2018	New York State Medical License
2017-present	Illinois Medical License
2011-present	Certification in Adult Psychiatry, American Board of Psychiatry and Neurology
2013-present	Certification in Child and Adolescent Psychiatry, ABPN

Academic Appointments

2009-2011	Clinical Instructor, NYU Department of Child and Adolescent Psychiatry
2011-2017	Clinical Asst Professor, NYU Dept of Child and Adolescent Psychiatry
2017-2019	Clinical Assoc Professor, NYU Dept of Child and Adolescent Psychiatry
2011-2019	Clinical Director, NYU Gender and Sexuality Service
2015-2019	Co-Director, NYU Pediatric Consultation-Liaison Service
2019-present	Associate Professor of Child and Adolescent Psychiatry, Northwestern University
2019-present	Vice Chair of Clinical Affairs, Pritzker Department of Psychiatry and Behavioral Health, Lurie Children's Hospital of Chicago

Major Committee Assignments

International, National and Regional

2021-present	Sexual Orientation and Gender Identity Committee, Chair, AACAP
2019-present	WPATH Standards of Care Revision Committee, Children
2019-present	WPATH Standards of Care Revision Committee, Adult Mental Health
2015-2019	Department of Child Psychiatry Diversity Ambassador
2013-2021	Sexual Orientation and Gender Identity Committee Member, AACAP
2012-2019	Founder and Director, Gender Variant Youth and Family Network
2012-present	Association of Gay and Lesbian Psychiatrists, Transgender Health Committee
2012-2019	NYULMC, Chair LGBTQ Advisory Council
2012-2019	NYULMC, Child Abuse and Protection Committee
2013-2015	NYULMC, Pediatric Palliative Care Team
2003-2004	American Association of Medical Colleges (AAMC), Medical Education Delegate
2004-2006	AAMC, Western Regional Chair

Psychiatry Residency

2006-2009	Resident Member, Education Committee
2007-2008	Resident Member, Veterans Affairs (VA) Committee

Medical School

2002-2006	Chair, Diversity Curriculum Development Committee
2002-2006	AAMC, Student Representative
2003-2004	American Medical Student Assoc. (AMSA) World AIDS Day Coordinator
2003-2004	AMSA, Primary Care Week Coordinator
2004-2006	Chair, Humanism in Medicine Committee

Memberships, Offices, and Committee Assignments in Professional Societies

2006-present	American Psychiatric Association (APA)
2009-present	American Academy of Child and Adolescent Psychiatry (AACAP)
2011-present	World Professional Association for Transgender Health (WPATH)
2011-2019	Director, Gender Variant Youth and Family Network, NYC
2013-2019	Chair, NYU Langone Medical Center LGBTQ Council

Editorial Positions

2016-2018	Clinical Assistant Editor, *Transgender Health*
2014-present	Ad Hoc Reviewer, *LGBT Health.*
2016-present	Ad Hoc Reviewer, *JAACAP*
2018-present	Associate Editor, *Transgender Health*
2020-present	Ad Hoc Reviewer, *Pediatrics*

Principal Clinical and Hospital Service Responsibilities

2011-2019	Staff Psychiatrist, Pediatric Consultation Liaison Service
2011-2019	Faculty Physician, NYU Child Study Center
2011-2019	Founder and Clinical Director, NYU Gender & Sexuality Service

2015-2019	Co-Director, Pediatric Consultation Liaison Service
2019-present	Vice Chair, Pritzker Dept of Psychiatry and Behavioral Health
2019-present	Chief Psychiatrist, Gender Development Program
2020-present	Medical Director, Outpatient Psychiatry Services

Relevant Program Development

Gender and Sexuality Service

-founded by Aron Janssen in 2011, who continues to direct the service

-first mental health service dedicated to transgender youth in NYC

-served over 200 families in consultation, with 2-3 referrals to the gender clinic per week

-trained over 500 mental health practitioners in transgender mental health – 1 or 2 full day trainings in partnership with the Ackerman Institute's Gender and Family Project (GFP) and with WPATH Global Educational Initiative (GEI)

-New hires in Adolescent Medicine, Psychology, Plastic Surgery, Urology, Gynecology, Endocrinology, Social Work, Department of Population Health with focus on transgender care has led to expansion of available services for transgender youth at NYULMC in partnership with the Gender and Sexuality Service

-development of partnerships with Ackerman Institute, Callen-Lorde Health Center – both institutions have been granted access to our IRB and have agreed to develop shared research and clinical priorities with the Gender and Sexuality Service.

-multiple IRB research projects underway, including in partnership with national and international clinics

-model has been internationally recognized

Clinical Specialties/Interests

Gender and Sexual Identity Development
Co-Occurring Mental Health Disorders in Transgender children, adolescents and adults
Pediatric Consultation/Liaison Psychiatry
Psychotherapy
Gender Affirmative Therapy, Supportive Psychotherapy, CBT, MI

Teaching Experience

2002-2006	Course Developer and Instructor, LGBT Health (University of Colorado School of Medicine
2011-2019	Instructor, Cultural Competency in Child Psychiatry (NYU Department of Child and Adolescent Psychiatry) – 4 hours per year
2011-2019	Course Director, Instructor "Sex Matters: Identity, Behavior and Development" – 100 hours per year
2011-2019	Course Director, LGBT Mental Health Elective (NYU Department of Psychiatry) - 50 hours of direct supervision/instruction per year
2011-2019	Course Director, Transgender Mental Health (NYU Department of Child and Adolescent Psychiatry – course to begin in Spring 2018.
2015-2019	Instructor, Gender & Health Selective (NYU School of Medicine) – 4 hours per year.

Academic Assignments/Course Development

New York University Department of Child and Adolescent Mental Health Studies

-Teacher and Course Director: "Sex Matters: Identity, Behavior and Development."
A full semester 4 credit course, taught to approximately 50 student per year since 2011, with several students now in graduate school studying sexual and gender identity development as a result of my mentorship.

NYU Department of Child and Adolescent Psychiatry

-Instructor: Cultural Competency in Child and Adolescent Psychiatry

-Director: LGBTQ Mental Health Elective

World Professional Association of Transgender Health

-Official Trainer: Global Education Initiative – one of two child psychiatrists charged with training providers in care of transgender youth and adults.

Peer Reviewed Publications

1. Janssen, A., Erickson-Schroth, L., "A New Generation of Gender: Learning Patience from our Gender Non-Conforming Patients," Journal of the American Academy of Child and Adolescent Psychiatry, Volume 52, Issue 10, pp. 995-997, October, 2013.
2. Janssen, A., et. al. "Theory of Mind and the Intolerance of Ambiguity: Two Case Studies of Transgender Individuals with High-Functioning Autism Spectrum
3. Janssen A, Huang H, and Duncan C., Transgender Health. February 2016, "Gender Variance Among Youth with Autism: A Retrospective Chart Review." 1(1): 63-68. doi:10.1089/trgh.2015.0007.
4. Goedel WC, Reisner SL, Janssen AC, Poteat TC, Regan SD, Kreski NT, Confident G, Duncan DT. (2017). Acceptability and Feasibility of Using a Novel Geospatial Method to Measure Neighborhood Contexts and Mobility Among Transgender Women in New York City. Transgender Health. July 2017, 2(1): 96-106.
5. Janssen A., et. al., "Gender Variance Among Youth with ADHD: A Retrospective Chart Review," in review
6. Janssen A., et. al., "Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents," Journal of Child & Adolescent Psychology, 105-115, January 2018.
7. Janssen A., et. al., "A Review of Evidence Based Treatments for Transgender Youth Diagnosed with Social Anxiety Disorder," Transgender Health, 3:1, 27–33, DOI: 10.1089/ trgh.2017.0037.
8. Janssen A., et. al., "'The Complexities of Treatment Planning for Transgender Youth with Co-Occurring Severe Mental Illness: A Literature Review and Case Study," Archives of Sexual Behavior, 2019. # 3563492
9. Kimberly LL, Folkers KM, Friesen P, Sultan D, Quinn GP, Bateman-House A, Parent B, Konnoth C, Janssen A, Shah LD, Bluebond-Langner R, Salas-Humara C., "Ethical Issues in Gender-Affirming Care for Youth," Pediatrics, 2018 Dec;142(6).
10. Strang JF, Janssen A, Tishelman A, Leibowitz SF, Kenworthy L, McGuire JK, Edwards-Leeper L, Mazefsky CA, Rofey D, Bascom J, Caplan R, Gomez-Lobo V, Berg D, Zaks Z, Wallace GL, Wimms H, Pine-Twaddell E, Shumer D, Register-Brown K, Sadikova E, Anthony LG., "Revisiting the Link: Evidence of the Rates of

Autism in Studies of Gender Diverse Individuals," Journal of the American Academy of Child and Adolescent Psychiatry, 2018 Nov;57(11):885-887.

11. Goedel William C, Regan Seann D, Chaix Basile, Radix Asa, Reisner Sari L, Janssen Aron C, Duncan Dustin T, "Using global positioning system methods to explore mobility patterns and exposure to high HIV prevalence neighbourhoods among transgender women in New York City," Geospatial Health, 2019 Jan; 14(2): 351-356.
12. Madora, M., Janssen, A., Junewicz, A., "Seizure-like episodes, but is it really epilepsy?" Current Psychiatry. 2019 Aug; 18(8): 42-47.
13. Janssen, A., Busa, S., Wernick, J., "The Complexities of Treatment Planning for Transgender Youth with Co-Occurring Severe Mental Illness: A Literature Review and Case Study," Archives of Sexual Behavior. 2019 Oct; 48(7): 2003-2009.
14. Wernick Jeremy A, Busa Samantha, Matouk Kareen, Nicholson Joey, Janssen Aron, "A Systematic Review of the Psychological Benefits of Gender-Affirming Surgery," Urol Clin North Am. 2019 Nov; 46(4): 475-486.
15. Strang, J.F., Knauss, M., van der Miesen, A.I.R., McGuire, J., Kenworthy, L., Caplan, R., Freeman, A.J., Sadikova, E., Zacks, Z., Pervez, N., Balleur, A., Rowlands, D.W., Sibarium, E., McCool, M.A., Ehrbar, R.D., Wyss, S.E., Wimms, H., Tobing, J., Thomas, J., Austen, J., Pine, E., Willing, L., Griffin, A.D., Janssen, A., Gomez-Lobo, A., Brandt, A., Morgan, C., Meagher, H., Gohari, D., Kirby, L., Russell, L., Powers, M., & Anthony, L.G., (in press 2020). A clinical program for transgender and gender-diverse autistic/neurodiverse adolescents developed through community-based participatory design. *Journal of Clinical Child and Adolescent Psychology.* DOI 10.1080/15374416.2020.1731817
16. Coyne, C. A., Poquiz, J. L., Janssen, A., & Chen, D. Evidence-based psychological practice for transgender and non-binary youth: Defining the need, framework for treatment adaptation, and future directions. Evidence-based Practice in Child and Adolescent Mental Health.
17. Janssen, A., Voss, R.. Policies sanctioning discrimination against transgender patients flout scientific evidence and threaten health and safety. Transgender Health.
18. Dubin, S., Cook, T., Liss, A., Doty, G., Moore, K., Janssen, A. (In press 2020). Comparing Electronic Health Records Domains' Utility to Identify Transgender Patients. Transgender Health, DOI 10.1089/trgh.2020.0069

Published Abstracts

1. Thrun, M., Janssen A., et. al. "Frequency of Patronage and Choice of Sexual Partners may Impact Likelihood of HIV Transmission in Bathhouses," original research poster presented at the 2007 Conference on Retroviruses and Opportunistic Infections, February, 2007.
2. Janssen, A., "Advocating for the mental health of Lesbian, Gay, Bisexual and Transgender (LGBT) population: The Role of Psychiatric Organizations." Workshop for the American Psychiatric Association Institute of Psychiatric Services Annual Meeting, October 2012.
3. Janssen, A., "Gender Variance in Childhood and Adolescents: Training the Next Generation of Psychiatrists," 23rd Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, February 2014.

4. Janssen, A., "When Gender and Psychiatric Acuity/Comorbidities Overlap: Addressing Complex Issues for Gender Dysphoric and Non-Conforming Youth," AACAP Annual Meeting, October 2014.
5. Janssen, A., "Patient Experiences as Drivers of Change: A unique model for reducing transgender health disparities as an academic medical center," Philadelphia Transgender Health Conference, June 2016.
6. Janssen, A., "How much is too much? Assessments & the Affirmative Approach to TGNC Youth," 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.
7. Janssen, A., "Trauma, Complex Cases and the Role of Psychotherapy," 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.
8. Janssen, A., "Gender Variance Among Youth with Autism: A Retrospective Chart Review," Research Poster, 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.
9. Janssen, A., "Gender Fluidity and Gender Identity Development," Center for Disease Control – STD Prevention Conference, September 2016.
10. Janssen, A., "Transgender Identities Emerging During Adolescents' Struggles With Mental Health Problems," AACAP Annual Conference, October 2016.
11. Janssen, A., "How Much is Too Much? Assessments and the Affirmative Approach to Transgender and Gender Diverse Youth," US Professional Association for Transgender Health Inaugural Conference, Los Angeles, February 2017.
12. Janssen, A., "Trauma, Complex Cases and the Role of Psychotherapy," US Professional Association for Transgender Health Inaugural Conference, Los Angeles, February 2017.
13. Sutter ME, Bowman-Curci M, Nahata L, Tishelman AC, Janssen AC, Salas-Humara C, Quinn GP. Sexual and reproductive health among transgender and gender-expansive AYA: Implications for quality of life and cancer prevention. Oral presentation at the Oncofertility Consortium Conference, Chicago, IL. November 14, 2017.
14. Janssen, A., Sidhu, S., Gwynette, M., Turban, J., Myint, M., Petersen, D., "It's Complicated: Tackling Gender Dysphoria in Youth with Autism Spectrum Disorders from the Bible Belt to New York City," AACAP Annual Conference, October 2017.
15. May 2018: "A Primer in Working with Parents of Transgender Youth," APA Annual Meeting.
16. October 2018: "Gender Dysphoria Across Development" – Institute for AACAP Annual Conference.
17. November 2018: "Gender Variance Among Youth with Autism," World Professional Association for Transgender Health Biannual Conference.
18. March 2019: "Gender Trajectories in Child and Adolescent Development and Identity," Austin Riggs Grand Rounds.
19. Janssen, A., et. al., "Ethical Principles in Gender Affirming Care," AACAP Annual Conference, October 2019.

20. Janssen, A., "Gender Diversity and Gender Dysphoria in Youth," EPATH Conference, April 2019
21. Englander, E., Janssen A., et. al., "The Good, The Bad, and The Risky: Sexual Behaviors Online," AACAP Annual Conference, October 2020
22. Englander, E., Janssen, A., et. al., "Love in Quarantine," AACAP Annual Conference, October 2021
23. Janssen, A., Leibowitz, S., et. al., "The Evidence and Ethics for Transgender Youth Care: Updates on the International Standards of Care, 8th Edition," AACAP Annual Conference, October 2021
24. Turban, J., Janssen, A., et. al., "Transgender Youth: Understanding "Detransition," Nonlinear Gender Trajectories, and Dynamic Gender Identities," AACAP Annual Conference, October 2021

Books

1. Janssen, A., Leibowitz, S (editors), Affirmative Mental Health Care for Transgender and Gender Diverse Youth: A Clinical Casebook, Springer Publishing, 2018.

Book Chapters

1. Janssen, A., Shatkin, J., "Atypical and Adjunctive Agents," Pharmacotherapy for Child and Adolescent Psychiatric Disorders, 3rd Edition, Marcel Dekker, Inc, New York, 2012.
2. Janssen, A; Liaw, K: "Not by Convention: Working with People on the Sexual & Gender Continuum," book chapter in The Massachusetts General Hospital Textbook on Cultural Sensitivity and Diversity in Mental Health. Humana Press, New York, Editor R. Parekh, January 2014.
3. Janssen, A; Glaeser, E., Liaw, K: "Paving their own paths: What kids & teens can teach us about sexual and gender identity," book chapter in Cultural Sensitivity in Child and Adolescent Mental Health, MGH Psychiatry Academy Press, Editor R. Parekh, 2016
4. Janssen A., "Gender Identity," Textbook of Mental and Behavioral Disorders in Adolescence, February 2018.
5. Busa S., Wernick, J., & Janssen, A. (In Review) Gender Dysphoria in Childhood. Encyclopedia of Child and Adolescent Development. Wiley, 2018.
6. Janssen A., Busa S., "Gender Dysphoria in Childhood and Adolescence," Complex Disorders in Pediatric Psychiatry: A Clinician's Guide, Elsevier, Editors Driver D., Thomas, S., 2018.
7. Wernick J.A., Busa S.M., Janssen A., Liaw K.RL. "Not by Convention: Working with People on the Sexual and Gender Continuum." Book chapter in The Massachusetts General Hospital Textbook on Diversity and Cultural Sensitivity in Mental Health, editors Parekh R., Trinh NH. August, 2019.
8. Weis, R., Janssen, A., & Wernick, J. The implications of trauma for sexual and reproductive health in adolescence. In *Not Just a nightmare: Thinking beyond PTSD to help teens exposed to trauma.* 2019
9. Connors J., Irastorza, I., Janssen A., Kelly, B., "Child and Adolescent Medicine," The Equal Curriculum: The Student and Educator Guide to LGBTQ Health, editors Lehman J., et al. November 2019.

10. Janssen, A., et. al., "Gender and Sexual Diversity in Childhood and Adolescence," Dulcan's Textbook of Child and Adolescent Psychiatry, 3rd edition, editor Dulcan, M., (in press)
11. Busa S., Wernick J, Janssen, A., "Gender Dysphoria," The Encyclopedia of Child and Adolescent Development, DOI: 10.1002/9781119171492. Wiley, December 2020.

Invited Academic Seminars/Lectures

1. April 2006: "How to Talk to a Gay Medical Student" – presented at the National AAMC Meeting.
2. March 2011: "Kindling Inspiration: Two Model Curricula for Expanding the Role of Residents as Educators" – workshop presented at National AADPRT Meeting.
3. May 2011: Janssen, A., Shuster, A., "Sex Matters: Identity, Behavior and Development," Grand Rounds Presentation, NYU Department of Child and Adolescent Psychiatry.
4. March 2012: Janssen, A., Lothringer, L., "Gender Variance in Children and Adolescents," Grand Rounds Presentation, NYU Department of Child and Adolescent Psychiatry.
5. June 2012: Janssen, A., "Gender Variance in Childhood and Adolescence," Grand Rounds Presentation, Woodhull Department of Psychiatry
6. October 2012: "Advocating for the mental health of Lesbian, Gay, Bisexual and Transgender (LGBT) population: The Role of Psychiatric Organizations." Workshop for the American Psychiatric Association Institute of Psychiatric Services Annual Meeting.
7. March 2013: "Gender Variance in Childhood and Adolescence," Sexual Health Across the Lifespan: Practical Applications, Denver, CO.
8. October 18th, 2013: "Gender Variance in Childhood and Adolescence," Grand Rounds Presentation, NYU Department of Endocrinology.
9. October, 2014: GLMA Annual Conference: "Theory of Mind and Intolerance of Ambiguity: Two Case Studies of Transgender Individuals with High-Functioning ASD," Invited Presentation
10. October 2014: New York Transgender Health Conference: "Mental Health Assessment in Gender Variant Children," Invited Presentation.
11. November, 2014: Gender Spectrum East: "Affirmative Clinical Work with Gender-Expansive Children and Youth: Complex Situations."
12. October 2015: "Gender Dysphoria and Complex Psychiatric Co-Morbidity," LGBT Health Conference, Invited Speaker
13. October 2015: "Transgender Health Disparities: Challenges and Opportunities," Grand Rounds, Illinois Masonic Department of Medicine
14. November 2015: "Autism and Gender Variance," Gender Conference East, Invited Speaker
15. February 2016: "Working with Gender Variant Youth," New York State Office of Mental Health State Wide Grand Rounds, Invited Speaker
16. March, 2016: "Working with Gender Variant Youth," National Council for Behavioral Health Annual Meeting, Invited Speaker

17. March 2016: "Gender Variance Among Youth with Autism: A Retrospective Chart Review and Case Presentation," Working Group on Gender, Columbia University, Invited Speaker.
18. September, 2016: "Best Practices in Transgender Mental Health: Addressing Complex Issues for Gender Dysphoric and Non-Conforming Youth," DeWitt Wallace Institute for the History of Psychiatry, Weill Cornell.
19. October, 2016: "LGBTQ Youth Psychiatric Care," Midwest LGBTQ Health Symposim
20. October, 2016: "Gender Fluidity and Gender Identity Development," NYU Health Disparities Conference.
21. February, 2017: "Best Practices in Transgender Mental Health," Maimonides Grand Rounds
22. March, 2017: "Transgender Health: Challenges and Opportunities," Invited speaker, Center for Disease Control STD Prevention Science Series.
23. September 2017: "Autism and Gender Dysphoria," Grand Rounds, NYU Department of Neurology.
24. November 2017: "Consent and Assent in Transgender Adolescents," Gender Conference East.
25. November 2017: "Transgender Mental Health: Challenges and Opportunities," Grand Rounds, Lenox Hill Hospital.
26. April 2018: "Gender Trajectories in Childhood and Adolescent Development and Identity," Sex, Sexuality and Gender Conference, Harvard Medical School.
27. September 2019: "Social and Psychological Challenges of Gender Diverse Youth," Affirmative Mental Health Care for Gender Diverse Youth, University of Haifa.
28. October 2019: "Best Practices in Transgender Mental Health," Grand Rounds, Rush Department of Psychiatry.
29. February 2020: "The Overlap of Autism and Gender Dysphoria," Grand Rounds, Northwestern University Feinberg School of Medicine Department of Psychiatry
30. February 2020: "Gender Dysphoria and Autism," Grand Rounds, University of Illinois at Chicago Department of Psychiatry
31. September 2021: "Gender Diversity and Autism," Grand Rounds, Kaiser Permanente Department of Pediatrics
32. October 2021: Gender Dysphoria and Autism," Grand Rounds, Case Western Reserve University Department of Psychiatry.

Selected Invited Community Seminars/Lectures

1. April 2012: "Gender and Sexuality in Childhood and Adolescence," Commission on Race, Gender and Ethnicity, NYU Steinhardt Speakers Series.
2. February 2013: "Supporting Transgender Students in School," NYC Independent School LGBT Educators Panel, New York, NY.
3. June 2013: "LGBT Health," Presentation for Neuropsychology Department
4. August 2013: "Chronic Fatigue Syndrome: Etiology, Diagnosis and Management," invited presentation.
5. September 2013: Panelist, "LGBTQ Inclusive Sex Education."
6. April 2015: Transgender Children, BBC News, BBCTwo, invited expert

7. January 2016: Gender Dysphoria and Autism – Ackerman Podcast - http://ackerman.podbean.com/e/the-ackerman-podcast-22-gender-dysphoria-autism-with-aron-janssen-md/
8. February 2016: "Best Practices in Transgender Mental Health," APA District Branch Meeting, Invited Speaker.
9. May 2016: "Best Practices in Transgender Mental Health," Washington D.C., District Branch, APA, Invited Speaker
10. July 2016: "Transgender Youth," Union Square West
11. November 2017: "Understanding Gender: Raising Open, Accepting and Diverse Children," Heard in Rye, Conversations in Parenting.
12. January 2018: "The Emotional Life of Boys," Saint David's School Panel, Invited Speaker
13. June 2018: "Supporting Youth Engaged in Gender Affirming Care," NYU Child Study Center Workshop.
14. October 2018: "Medicine in Transition: Advances in Transgender Mental Health," NYCPS HIV Psychiatry and LGBT Committee Meeting.
15. October 2018: "Understanding Gender Fluidity in Kids," NYU Slope Pediatrics.
16. October, 2021: Issues of Ethical Importance: Health Care for Pediatric LGBTQ+ Patients, American Medical Association, Invited Talk

Major Research Interests

Gender and Sexual Identity Development
Member, Research Consortium for Gender Identity Development
Delirium: Assessment, Treatment and Management
Suicide Prevention

Research Studies

Study Title	IRB Study#	Dates
Suicide Attempts Identified in a Children's Hospital Before and During COVID-19	2021-4428	2/26/21-present
Lurie Children's Sex & Gender Development Program Clinical Measure Collection	2019-2898	2019-present
Adolescent Gender Identity Research Study (principal investigator) - unfunded	s15-00431	4/15-5/19
Co-Occurrence of Autism Spectrum Disorders and Gender Variance: Retrospective Chart Review (principal investigator) - unfunded	s14-01930	10/14-5/19
Expert Consensus on Social Transitioning Among Prepubertal Children Presenting with Transgender Identity and/or Gender Variance: A Delphi Procedure Study (principal investigator) - unfunded	s13-00576	3/16-5/19

Co-Occurrence of ADHD/Gender Dysphoria (principal investigator) - unfunded	s16-00001	1/16-5/19
PICU Early Mobility- unfunded	s16-02261	12/16-5/19
Metformin for Overweight and Obese Children and Adolescents with Bipolar Spectrum Disorders Treated with Second-Generation Antipsychotics – Funded by PCORI	s16-01571	8/16-5/19

Other

Grant Funding:
Zero Suicide Initiative, PI Aron Janssen, M.D.
Awarded by Cardinal Health Foundation, 9/2020
Total amount: $100,000

Catalyst Fund, PI Aron Janssen, M.D.
Suicide Prevention in Pediatric Primary Care
Total amount: $750,000

Selected Media Appearances:

Guest Expert on Gender Identity on Anderson, "When Your Husband Becomes Your Wife," Air Date February 8th, 2012
Guest Host, NYU About Our Kids on Sirius XM, 2011
NYU Doctor Radio: LGBT Health, September 2013
NYU Doctor Radio: LGBT Kids, November 2013
NYU Doctor Radio: LGBT Health, July 2014
NYU Doctor Radio: Gender Variance in Childhood, December 2014
BBC Two: Transgender Youth, April 2015
NYU Doctor Radio: Transgender Youth, June 2015
Fox-5 News: Trump's proposed military ban and Transgender Youth, July, 2017
Healthline.com: Mental Health Experts Call President's Tweets 'Devastating' for Trans Teens, July, 2017
Huffington Post: What the Military Ban Says to Our Transgender Youth: August, 2017
Metro: How to talk to your transgender kid about Trump, August 2017
NYU Doctor Radio: Transgender Youth, August 2017

Exhibit B

Appendix

APPENDIX

American Academy of Child & Adolescent Psychiatry Policy Statement: Conversion Therapy (2018).

American Psychiatric Association Position Statement on Conversion Therapy and LGBTQ Patients (2018).

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist, 70*(9), 832–864.

American Psychological Association Resolution on Gender Identity Change Efforts (2021). American

Psychologist, 70(9), 832–864.

Achille, C., et al. (2020). Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: Preliminary results. International Journal of Pediatric Endocrinology, 2020.

Chen D, Berona J, Chan YM, Ehrensaft D, Garofalo R, Hidalgo MA, Rosenthal SM, Tishelman AC, Olson-Kennedy J. Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. N Engl J Med. 2023 Jan 19;388(3):240-250.

Costa, R., et al. (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. The Journal of Sexual Medicine, 12(11), 2206–2214.

De Vries ALC, et al. (2011). Psychiatric comorbidity in gender dysphoric adolescents. Journal of Child Psychology & Psychiatry. 52(11):1195-1202.

De Vries ALC, et al. Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics. 2014; 134:1–9.

Durwood, et al. (2017). Mental health and self-worth in socially transitioned transgender youth. Journal of the American Academy of Child & Adolescent Psychiatry, 56, 116–123.

Edwards-Leeper, L., & Spack, N. P. (2012). Psychological evaluation and medical treatment of transgender youth in an interdisciplinary "Gender Management Service" (GeMS) in a major pediatric center. Journal of Homosexuality, 59, 321–336.

Gibson, D. J., et al. (2021). Evaluation of anxiety and depression in a community sample of transgender youth. JAMA network open, 4(4), e214739-e214739.

Green, A. E., et al (2021). Association of gender-affirming hormone therapy with depression, thoughts of suicide, and attempted suicide among transgender and nonbinary youth. Journal of Adolescent Health [ePublication ahead of print].

Hidalgo, M. A., et al. (2013). The gender affirmative model: What we know and what we aim to learn. Human Development, 56(5), 285-290.

Klein A, Golub SA. (2016) Family Rejection as a Predictor of Suicide Attempts and Substance Misuse Among Transgender and Gender Nonconforming Adults. LGBT Health. 3(3):193-9.

Klein D, Paradise S, Goodwin E. Caring for Transgender and Gender Diverse Persons: What Clinicians Should Know. (2018) American Family Physician, 98(11).

Kuper, L. E., et al (2020). Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy. Pediatrics, 145(4), e20193006.

Olson, et al. (2016). Mental health of transgender children who are supported in their identities. Pediatrics, 137, e20153223.

Olson, Johanna, et al. (2019). Creating the Trans Youth Research Network: A Collaborative Research Endeavor. Transgender Health. 4. 304-31

Rae JR, et al. (2019). Predicting Early-Childhood Gender Transitions. Psychol Sci. 30(5):669-681.

Ryan C, et al. (2010). Family acceptance in adolescence and the health of LGBT young adults. J Child Adolesc Psychiatr Nurs. 23(4):205-13;

Steensma TD, et al. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. J Am Acad Child Adolesc Psychiatry. 52(6):582-90.

Tordoff DM, Wanta et al. (2022) Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. JAMA Netw Open. 5(2):e220978. doi:10.1001/jamanetworkopen.2022.0978.

Turban J, DeVries A & Zucker K, *Gender Incongruence & Gender Dysphoria*, in *Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook*, (A Martin, et al., eds., 5th ed., 2018).

Turban JL, et al. (2020) Pubertal suppression for transgender youth and risk of suicidal ideation, Pediatrics. 145(2):e20191725.

Turban JL, et al. (2021). Timing of Social Transition for Transgender and Gender Diverse Youth, K-12 Harassment, and Adult Mental Health Outcomes. J Adolesc Health 69(6):991-998.

Van der Miesen, A., et al. (2020). Psychological functioning in transgender adolescents before and after gender- affirmative care compared with cisgender general population peers. The Journal of Adolescent Health, 66(6), 699.

White Hughto JM, et al. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Soc Sci Med*. 147:222-231.

World Professional Association for Transgender Health (WPATH) Standards of Care, Version 8, https://www.wpath.org/soc8/chapters.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY

JANE DOE 1; *et al*., *Plaintiffs*, v. WILLIAM C. THORNBURY, JR., MD, in his official capacity as the President of the Kentucky Board of Medical Licensure; *et al.*, *Defendants*.	**DECLARATION OF SUZANNE KINGERY, M.D.** Civil No. 3:23-cv-230-DJH

EXPERT DECLARATION OF SUZANNE KINGERY, M.D.

I, Suzanne Kingery, M.D., hereby declare as follows:

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

2. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

I. INTRODUCTION

A. Background and Qualifications

3. I am a licensed physician in Kentucky and I am Double Board certified by the American Board of Pediatrics in General Pediatrics and Pediatric Endocrinology.

4. I am a pediatric endocrinologist at Norton Children's Endocrinology in Louisville, Kentucky. I am the Director and co-founder of the Pediatric and Adolescent Gender Education ("PAGE") program at Norton Children's.

5. I am an Associate Professor of Pediatric Endocrinology at the University of Louisville School of Medicine. I am speaking on behalf of myself as a subject matter expert and not as a representative of the University or any hospital.

6. I graduated Davidson College in North Carolina in 2000 with a bachelor of science in biology.

7. I graduated the Medical College of Georgia in 2005.

8. I completed my Residency in Pediatrics at University of Louisville in 2008.

9. I completed my Fellowship in Pediatric Endocrinology from Nationwide Children's Hospital in 2011.

10. I trained under Dr. Robert Hoffman, M.D., and David Repaske, M.D., at Nationwide Children's in Columbus, Ohio. They have each trained hundreds of medical providers, participated in the development of national and international guidelines, treated thousands of children, held numerous grants and published numerous peer reviewed papers.

11. As a pediatric endocrinologist working in Norton Children's Hospital's PAGE program, I have extensive experience providing treatment for gender dysphoria to transgender minors through a multidisciplinary care model. The PAGE Clinic uses evidence-based standards and practices and has provided social, medical, and mental health support for transgender and gender diverse patients across the Commonwealth of Kentucky since 2015.

12. During my time practicing medicine at Norton Children's and University of Louisville, I received numerous scholarly awards. Most recently, I won the Faculty Peer Clinician-Teaching Excellence Award at the University of Louisville in 2023. At the University of Louisville, I have also won the Golden Apple Teaching Award (2022); Student Champion Award (2022); Outstanding Educator (2021); Faculty Favorite (2021, 2020); Trailblazer Innovation Award for the eQuality Toolkit (2021); Faculty Peer Clinician-Teaching Excellence Award (2020, 2019, 2016); American Medical Women's Association (AMWA) Gender Equity Award (2019); LGBT Center Ally Award (2018); Mid-Career Faculty Award (2018); Fitzbulter Award

Humanism in Medicine (2018); Top Ten Teaching Faculty of the Year (2018, 2016 and 2015) and Top Five Teaching Faculty of the Year (2017); American Medical Women's Association (AMWA) Gender Equity Award (2016). I won the Healthcare Hero award through Business First Louisville in 2022 and the Leonard Tow Humanism in Medicine Award through the Arnold P. Gold Foundation in 2018.

13. I am a member of the Pediatric Endocrine Society, and the American Academy of Pediatrics.

14. I am a member of the American Board of Pediatrics Endocrinology Subboard and I am a ScholarRx Faculty Advisor.

15. I have co-authored thirteen articles published in peer-reviewed journals and conducted numerous clinical trials.

16. In 2011, as a pediatric endocrinology assistant professor I began working with transgender children, adolescents and young adults. In 2015, I developed a multidisciplinary youth gender program. I have provided care for approximately 350 transgender young people for gender dysphoria. The best current estimate of the number of transgender patients under my care is 250. The number of adolescent patients who are prescribed hormone blocking medications and/or hormone therapy represent only a portion of all young people who are seen by the clinical team. Some adolescents are seen in clinic and never receive these treatments, and others are not ready for, or are not candidates for, these medications.

17. Multidisciplinary youth gender clinics provide social, medical and mental health support to gender-diverse youth and young adults and their families. We educate our patients and their families about gender identity development and gender nonconformity, and help empower our patients and families to make informed decisions with accurate information. Teams of

professionals include pediatric endocrinologists, psychologists (Licensed Clinical Social Workers and Licensed Marriage and Family Therapists), adolescent medicine physicians, and nurses. The care provided is consistent with the World Professional Association for Transgender Health (WPATH) Standards of Care and focuses on the biological, psychological, as well as social (biopsychosocial) components of transgender health. Services provided include consultation, psychotherapy, and assessment of medical indication for hormone blocking medications and/or hormone therapy. In addition to providing expert care, one goal is to provide a safe environment where patients and their families can receive social and emotional supports.

18. In my practice, I strive to provide the highest quality, evidence-based, individualized and compassionate care for my patients and their families. Ultimately, I strive to empower each patient to achieve their optimal physical, mental, emotional and social health, and want each person to feel that they are accepted and valued for who they are.

19. The information provided regarding my professional background, experiences, publications, and presentations is detailed in my curriculum vitae, a true and correct copy of the most up-to-date version of which is attached as **Exhibit A**.

B. Bases for Opinions

20. In preparing this report, I have relied upon my training and clinical experience, as set out in my curriculum vitae, and on the materials listed therein. I have also reviewed the materials listed in the attached bibliography, **Exhibit B**. The sources cited therein are authoritative, scientific per-reviewed publications. These are the same types of materials that experts in my field of study regularly rely upon when formulating opinions on the subject. I reserve the right to revise and supplement the opinions expressed in this report or the basis for them if any new information

becomes available in the future, including as a result of a new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

21. In addition, I have reviewed SB 150, Section 4.

C. Compensation

22. I am not compensated for my work on this matter for preparation of declarations and expert reports, and deposition and trial testimony. Compensation does not influence the opinions I express, or the testimony I may provide.

II. STANDARDS OF CARE FOR TREATING GENDER DYSPHORIA ARE WELL-ESTABLISHED

23. According to the 2022 *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), Text Revision*, gender dysphoria is a diagnosis defined as an individual having clinically significant psychological distress or impairment in social, occupational or other important areas of functioning that results from a marked incongruence between their sex assigned at birth and the person's gender identity (the gender with which the individual identifies). Gender dysphoria may manifest in childhood, at the onset of puberty, or in adulthood, and when left untreated it can result in adverse mental health outcomes such as severe anxiety, depression, suicidal ideation and self-harm.

24. I stay updated on the latest medical science and treatment protocols for the treatment of gender dysphoria in adolescents and young adults to ensure that I am providing the highest quality evidence-based care for my patient population. The available treatments for gender dysphoria are well established in the medical profession and the potential benefits of treatment are well-documented in the literature.

25. Comprehensive standards of care and clinical practice guidelines directing this treatment have been developed by the World Professional Association for Transgender Health

(WPATH)[1] and the Endocrine Society.[2] These guidelines have been adopted into practice by the profession as a standard of care. These standards of care are based on decades of scientific and medical research representing the best evidence-based practice information available for treating this condition. The treatment of gender dysphoria with transition-related care is recognized by nearly ever major medical professional association, including the American Medical Association, American Academy of Pediatrics, Society for Adolescent Health and Medicine, American Psychiatric Association, and the American Academy of Family Physicians, among others.

26. The current version of the WPATH Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (SOC-8), was released in September 2022. The prior SOC, Version 7, had been in place for more than a decade. Standards of care for treating gender dysphoria differ for prepubertal children (minors who have not started puberty), adolescents, and adults.

27. Treatment for gender dysphoria is aimed at eliminating the clinically significant distress that patients suffer by helping them explore, define, and express their gender identity openly and respectfully. This care model is referred to as "transition-related care," or "gender transition."

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[1] WPATH was founded in 1979 and aims to promote evidence-based care, education, research, public policy, and respect in transgender health. Internationally accepted Standards of Care (SOC) for health professionals are updated and revised as new scientific information becomes available. SOC8 was informed by a systematic review of the evidence and assessment of benefits and harms of alternative care options. Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *Int J Transgend Health.* 2022 Sep 6;23(Suppl1):S1-S259.

[2] Specifically, an Endocrine Society-appointed task force whose Clinical Practice Guidelines were published in The Journal of Clinical Endocrinology & Metabolism in 2017. 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 Nov 1;102(11):3869-3903.

28. Medications for treating gender dysphoria are not recommended for or prescribed to prepubertal children. Instead, support for a prepubertal transgender child may include social transition, which means allowing a child to live and be socially recognized in accordance with their gender identity rather than their sex assigned at birth. The social transition may include allowing the child to choose clothing, hairstyle, name, pronouns, and activities that correspond to that individual's gender identity.

29. Many transgender minors experience exacerbation of gender dysphoria when puberty begins. The development of secondary sex characteristics- breast development, body fat redistribution, facial changes, and onset of menses for transgender boys; androgenized hair growth, voice deepening, facial changes and increased musculature for transgender girls- has caused significantly heightened stress and anxiety in many of my transgender adolescent patients. In my experience treating transgender adolescents, without treatment for their gender dysphoria many patients can experience anxiety, interpersonal conflicts, depression, academic decline, social withdrawal, disordered eating patterns, and suicidal thoughts and attempts.

30. Once a transgender adolescent begins puberty, medications can be prescribed to temporarily halt the physical changes of puberty, avoiding the exacerbation of gender dysphoria and mitigating harms that can accompany the development of secondary sex characteristics. The temporary halt to puberty can be completely reversed if medication is stopped. However, if later in adolescence the patient, parents, and healthcare team decide that initiation of hormone therapy is in the patient's best interest, they may be able to avoid physical changes inconsistent with their gender identity.

31. Puberty is initiated by the pulsatile release of the hormone GnRH from the hypothalamus. GnRH then stimulates the pituitary gland to produce Follicle Stimulating Hormone

(FSH) and Luteinizing Hormone (LH). These hormones, FSH and LH, then lead to the production of estrogen and testosterone in individuals with ovaries and testes, respectively. Pubertal suppression involves the administration of a medication that prevents the release of FSH and LH, thereby inhibiting the production of estrogen and testosterone. By inhibiting that production, the further development of secondary sex characteristics halts. This pause in puberty limits the further influence of a person's endogenous sex hormones on the body. Stopping the medication resumes the production of FSH and LH and allows puberty to resume with no residual effects on fertility or secondary sex characteristics.

32. For some transgender adolescents, undergoing pubertal development consistent with their gender identity through hormone therapy may also be medically necessary and in their best interest. When prescribed hormone therapy- testosterone for transgender boys, and estrogen in combination with a testosterone-suppressing medication for transgender girls-adolescents experience physical changes consistent with their gender identity.

A. Mental Health Evaluations are Conducted Prior to Initiating Medical Treatment for Transgender Adolescents

33. WPATH SOC-8 recommends a multidisciplinary assessment that involves several domains for the patient seeking treatment for gender dysphoria. A licensed mental health professional with expertise in the treatment of transgender and gender diverse adolescents assessed the patient's gender identity development, social development, and the support structure for the patient, including an investigation of the effects of gender minority stress, family dynamics and any other aspect that might contribute to the individual's social development. Additionally, co-occurring mental health and/or developmental concerns are addressed. The mental health professional also assesses whether the minor has the emotional and cognitive maturity to provide informed assent for any treatment. This process of consent and assent involves an evaluation of

the minor's and guardian's understanding of the medical information and treatment, including the option to not receive treatment, risks and reversible and irreversible effects of treatment, and fertility options and considerations during an open discussion about the patient's goals and expectations of treatment.

34. Endocrine Society Guidelines specify that mental health clinicians who diagnose gender dysphoria should be trained "in child and adolescent developmental psychology and psychopathology," competent in using the DSM diagnostically, and able to understand the individual's mental health, social conditions and ability to consent. This process is highly individualized; a nuanced approach is indicated as each patient has unique medial needs.

B. Extensive Requirements Must Be Met Before Medical Interventions are Initiated for Transgender Adolescents

35. Medications for the treatment of gender dysphoria are not appropriate for every patient. The WPATH SOC-8 advises that "it is important to establish the young person has experienced several years of persistent gender diversity/incongruence prior to initiating less reversible treatments such as gender-affirming hormones…"[3] Similarly, the Endocrine Society Guidelines provides that prior to the initiation of any medical intervention, "transgender individuals should be encouraged to experience living in the new gender role and assess whether this improves their quality of life."[4]

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[3] Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *Int J Transgend Health*. 2022 Sep 6;23(Suppl 1):S60.

[4] 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 Nov 1;102(11): 3876.

36. Pursuant to the Endocrine Society Guideline, transgender adolescents with gender dysphoria may be eligible for pubertal blocking medication if a qualified mental health professional has confirmed that: (i) the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed); (ii) gender dysphoria worsened with the onset of puberty; (iii) any coexisting psychological, medical, or social problems that could interfere with treatment; and (iv) the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment.

37. Further, the adolescent must: (i) have been informed of the effects and side effects of treatment (including potential impacts on fertility if the individual subsequently continues with life-long sex hormone treatment) and options to preserve fertility; and (ii) 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.

38. Lastly, a pediatric endocrinologist or other clinician experienced in pubertal assessment should: (i) agree with the indication for GnRH agonist treatment; (ii) confirm that puberty has started in the adolescent; and (iii) confirm that there are no medical contraindications to GnRH agonist treatment. [5]

39. For a transgender adolescent to be eligible for hormone therapy, the Endocrine Society Guideline directs that a qualified mental health professional confirms: (i) the persistence of gender dysphoria; (ii) any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed,

[5] Specifically, an Endocrine Society-appointed task force whose Clinical Practice Guidelines were published in The Journal of Clinical Endocrinology & Metabolism in 2017. 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 Nov 1;102(11):3869-3903.

such that the adolescent's situation and functioning are stable enough to start hormone therapy; and (iii) the adolescent has sufficient mental capacity to estimate the consequences of this treatment, weigh the benefits and risks, and give informed consent to this treatment. [6]

40. Further, the adolescent needs to have: (i) been informed of the effects and side effects of treatment (including options to preserve fertility); (ii) given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process. And lastly, a pediatric endocrinologist or other clinician experienced in pubertal induction: (i) agrees with the indication for hormone therapy; and (ii) has confirmed that there are no medical contraindications to hormone therapy. [7]

III. THE MULTIDISCIPLINARY TREATMENT TEAM MODEL

41. I treat transgender patients as part of a multidisciplinary treatment team which includes mental health providers, pediatric endocrinologists, adolescent medicine physicians, and nurses, all of whom are experienced in providing care to transgender minor patients.

42. We follow the process outlined in the WPATH SOC-8 and the Endocrine Society Guidelines.

43. Keeping with the American Medical Association's Code of Medical Ethics, I follow a comprehensive informed consent process prior to initiating treatment.

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[6] 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 Nov 1;102(11):3869-3903.

[7] *Ibid*.

44. Some patients are referred to the clinic by a mental health provider with expertise in transgender health, while others are referred by their pediatrician or other provider. If the patient does not already have a mental health provider and is under the age of 18, I refer the patient to one to begin the mental health evaluation prior to providing any treatment. If the mental health provider is not affiliated with the PAGE clinic, I ensure the provider has a detailed account of the patient's symptoms of gender dysphoria and a pre-existing relationship with the patient. The mental health provider and I then work together collaboratively to assess the patient in accordance with the WPATH standards and Endocrine Society guidelines.

45. The mental health provider assesses the patient then I review the mental health assessment and confirm that there is a diagnosis of gender incongruence and that it has been consistent, persistent and insistent, along with confirming other relevant criteria. For many of my patients, gender dysphoria has been present for years prior to their visit. I further assess the patient for any medical or psychosocial conditions that might affect treatment. My interview with the patient and parent or guardian includes a thorough discussion of the patient's individual needs, goals, and their process of coming to understand and live in accordance with their gender identity.

46. Once both a mental health professional and I have each confirmed the diagnosis of gender dysphoria, I meet with the patient and parent or guardian as many times as is necessary for them to fully understand the risks and benefits of treatment options in their individual circumstance and come to an informed decision. As part of my evaluation, I order bloodwork to confirm puberty has started, and other necessary evaluation to assess the general health of the patient prior to initiating therapy. I also thoroughly discuss the potential impacts on fertility, fertility preservation options, and make appropriate referrals as necessary.

47. As part of my informed consent process with the patient and guardian, I discuss in detail the risks, benefits, and reversible and long-term effects of the relevant medications (pubertal suppressants and/or hormone therapies), and alternatives to treatment. As part of this process, I ask detailed questions to the patient and guardian to ensure understanding of the range of potential treatment options and outcomes. During this discussion, I discuss the options and types of medications used, and we offer to provide patients and their parents with additional research based articles and handouts to make an informed decision.

48. Once a full evaluation has been completed; the patient, family, and healthcare team are all in agreement that a treatment is in the best interest of the patient; and risks and benefits are well understood, informed consent and assent are obtained and treatment can commence. I obtain informed consent from the patient's parents in writing. I obtain informed consent from the patient verbally if they are under 18 and from the patient in writing, if they are over 18. My consent form specifically states the expected effects of medication, the possible risks and side effects of medication, and requires the parent agree to regular periodic check-ups after starting puberty blockers or hormones. I have never prescribed puberty blockers or hormones to a patient when the patient or patient's parent/guardian did not consent to treatment.

49. Consistent with the established treatment guidelines described above and as required by insurance companies, I perform a blood test to confirm the patient is undergoing puberty prior to prescribing puberty blockers. Additionally, I do not prescribe puberty blockers prior to Tanner Stage II. It can be a year or more after a patient initially comes to see me and before I will prescribe them puberty blockers or hormone therapy because they do not physically or psychologically meet the necessary criteria.

50. Once the patient begins their medical treatment as prescribed, I meet with the patient and family for follow up on a regular basis and their progress is monitored at regular intervals. I assess the patient's progress, presence of gender dysphoria, physical and mental health, efficacy of the treatment, satisfaction with the treatment, side effects, and hormone levels and laboratory screening for treatment side effects. At these follow-up appointments, we carefully reassess patient progress and make medication adjustments as appropriate. The patients are strongly encouraged to remain in therapy with a mental health provider throughout this process.

51. Depending on the needs of the patient, the pubertal stage they are in, and any changes that may have already resulted from endogenous puberty, patients may first initiate puberty blocking medication, followed by hormone therapy *if and when* it is medically indicated and the patient and family desire this treatment; or they may initiate hormone therapy alone or in conjunction with androgen receptor antagonists or pubertal suppressants at later stages of puberty. The goal of the treatment is to minimize the patient's gender dysphoria and to allow the patient to experience secondary sex characteristics consistent with their gender identity if medically indicated and agreed upon by the healthcare team, patient and family.

52. In my clinical experience, I have witnessed first-hand the significant and substantial benefits that access to puberty blocking, hormone antagonists, and hormone therapies, when medically necessary for the individual, can have on an adolescents' overall health and well-being.

IV. PUBERTY BLOCKING, HORMONE ANTAGONIST, AND HORMONE THERAPIES ARE SAFE AND EFFECTIVE TREATMENTS FOR TRANSGENDER YOUTH

53. I have read the SB150 Section 4 rules that bar doctors from prescribing puberty blocking, and hormone therapies for transgender youth. These bans stand in direct contrast to the authoritative standards of care for the treatment of gender dysphoria. Based on my expert opinion,

unless enjoined these rules will continue to cause harm to my patients and countless other transgender youth in the Commonwealth of Kentucky.

54. The Endocrine Society's and WPATH's treatment protocols for prescribing puberty blocking medications and hormone therapies provide an evidence-based, safe and effective treatment approach for gender dysphoria. The American Academy of Pediatrics, which was founded in 1930 and represents more than 67,000 pediatricians in this county, is one of many reputable medical associations in the United States which supports the use of puberty blocking medications and hormone therapy to treat gender dysphoria in adolescent patients when medically indicated.

55. Puberty blocking treatment works by pausing endogenous puberty at whatever stage it is at when the treatment begins, limiting the further influence of endogenous hormones until the treatment is ended. Puberty blocking medications are not new for the treatment of gender dysphoria, as their use began in Amsterdam in 1998 and expanded to the United States in 2010. Puberty blocking medications are safely used to treat precocious puberty in non-transgender youth. There is over 30 years' worth of data on the safety of puberty blockers regarding children who experience precocious puberty that can be applied to the transgender population.

56. In appropriate candidates, the benefits of treating gender dysphoria with puberty blocking medication can greatly outweigh the small potential for short- or long-term side effects. Moreover, for youth with gender dysphoria, as compared to those treated for precocious puberty, the treatment is typically used for a much shorter period to pause development before either initiating puberty with hormone therapy or resuming endogenous puberty.

57. Pubertal development has a wide variation among individuals. The onset of puberty in individuals whose sex assigned at birth is male begins, on average, at age 11-12 but can range

from age 9 to 14. In those whose sex assigned at birth is female, the onset of puberty typically begins at age 10-11, but can range from age 8 to 13. Once puberty begins, completion on average occurs 3.5-4 years later. Generally speaking, pubertal suppression occurs for up to 2-3 years. The use of puberty blockers in transgender males (whose sex assigned at birth is female) allows for decreased chest development, reducing the need for breast binding and potential surgical intervention in adulthood. The use of puberty blockers in transgender females (whose sex assigned at birth is male), limits facial and body hair growth, voice deepening, and testosterone-driven cartilage and bone structure changes, which greatly reduce distress both at the time of treatment and later in life reduce the need for future interventions such as voice therapy, hair removal, and facial feminization surgery.

58. The use of puberty blocking medications are safe and effective, and the rare side effects are thoroughly discussed with the patient and their family prior to starting any treatment. To address the risk of lower bone mineral density that can be associated with prolonged use of puberty blockers, we advise adequate intake of Vitamin D and calcium (and screen for deficiencies with lab-work and bone mineral density scans when deemed appropriate), regular weight-bearing exercise, and limit the number of years a patient is on puberty blocking medication. Decades of data on the use of puberty blockers as treatment for precocious puberty has demonstrated that puberty blocking medication does not have long-term implications for fertility. [8,9]

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[8] Guaraldi F, Beccuti G, Gori D, Ghizzoni L. MANAGEMENT OF ENDOCRINE DISEASE: Long-term outcomes of the treatment of central precocious puberty. Eur J Endocrinol. 2016 Mar;174(3):R79-87.

[9] Martinerie L, de Mouzon J, Blumberg J, di Nicola L, Maisonobe P, Carel JC; PREFER study group. Fertility of Women Treated during Childhood with Triptorelin (Depot Formulation) for Central Precocious Puberty: The PREFER Study. Horm Res Paediatr. 2020;93(9-10):529-538.

59. Puberty blocking medications may also be used by transgender females (whose sex assigned at birth is male) in conjunction with estrogen therapy to suppress that individual's endogenous production of testosterone. It is standard protocol to include a testosterone-suppressive agent when an individual begins estrogen. Hormone receptor antagonist therapies can also be used to suppress the endogenous action of testosterone. There are some instances where puberty-blocking medications are used in the latter stages of puberty to prevent unwanted secondary sex characteristics such as an Adam's apple, increased facial hair, a lower voice or late-stage breast development, depending on the individualized needs and assessment of the patient.

60. In a 2020 study published in the American Academy of Pediatrics' official journal *Pediatrics*, researchers queried a group of 20,619 transgender individuals and found a lower odds of lifetime suicidal ideation for those who received pubertal suppression when they were adolescents compared with a group that desired pubertal suppression when they were adolescents compared with a group that desired pubertal suppression but did not receive it. [10] Suicidality is of particular concern because the estimated lifetime prevalence of suicide attempts among the transgender population is as high as 40%- nearly nine times the attempted suicide rate in the U.S. population. [11]

61. Under the Endocrine Society Guidelines and WPATH SOC-8, hormone therapy is appropriate for transgender adolescents with gender dysphoria when their experience of gender incongruence is marked and sustained over time, the adolescent demonstrates emotional and

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[10] Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. Pediatrics. 2020 Feb;145(2):e20191725.

[11] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

cognitive maturity required to provide informed consent/assent for treatment, other mental health concerns (if any) that may interfere with diagnostic clarity and capacity to consent have been addressed, and the adolescent has discussed reproductive options with their provider. For adolescents who meet these criteria, it may be in the patient's best interest to provide hormone therapy to initiate puberty consistent with the patient's gender identity. The parent or guardian is critical to the assessment and treatment process for minors and must provide informed consent for any individual under the age of majority.

62. Hormone therapy is safe and has been used in non-transgender patients for reasons unrelated to the treatment of gender dysphoria. The main types of medical conditions in childhood where estrogen or testosterone are prescribed for non-transgender youth are (i) Disorders of Sex Development (DSD), which amounts to approximately 5% of all endocrinology patients, and (ii) panhypopituitarism, which accounts for 2-5% of all endocrinology patients and (iii) disorders of puberty, which accounts for 8% of all endocrinology patients. Common examples of diseases that fall under these disease categories where hormones are prescribed include, but are not limited to, polycystic ovary syndrome, menorrhagia (heavy menstrual bleeding), acne, contraception, post-chemotherapy or radiation therapy, premature ovarian failure, pubertal delay, Kallman syndrome, and testosterone deficiency. Additionally, patients with various intersex or DSD conditions, such as Turner Syndrome, Klinefelter Syndrome, congenital adrenal hyperplasia, androgen insensitivity syndrome, gonadal dysgenesis, and ovotesticular DSD also often receive hormone therapy. Those individuals with the conditions described often need hormone therapy for the duration of their entire lives.

63. As with puberty blocking medications, I discuss the risks and benefits of hormone therapy at length with adolescent patients and their families prior to the initiation of treatment.

Potential impact on fertility is always discussed along with fertility preservation options. If desired after our discussion, patients are referred to a reproductive endocrinologist for further discussion of fertility preservation, a procedure that also may be recommended prior to certain chemotherapy regimens or due to ovarian or testicular toxicity.

64. Many transgender adults have been on hormone therapy for decades. No reputable medical organization or reliable study has concluded that the risk of any negative outcome would categorically outweigh the substantial benefit of treatment in appropriate candidates for therapy.

65. The goal of hormone therapy is to lessen gender dysphoria, improve functioning and avoid unwanted secondary sex characteristics while developing characteristics that align with gender identity. Studies have showed improved psychological functioning, body image and mental health, and less gender dysphoria, suicidality, depression and anxiety with treatment for gender dysphoria. Some of my patients who are receiving medical treatment for gender dysphoria experienced suicidal ideation and attempts prior to beginning treatment. I have witnessed patients transform from individuals with significant levels of psychological distress to functional, psychologically stable, thriving individuals. I fear that categorically denying puberty blockers, hormone antagonists, and hormones to transgender adolescents who meet criteria for care will lead to distress and psychological harm.

66. After medications are initiated, the patient's functioning, psychosocial situation, physical changes, satisfaction with therapy, hormone levels, and treatment side effects are assessed every 3 to 6 months. Patient care is individualized and in consultation with their medical provider, patients may decide to stop therapy, continue, or be evaluated for adjustment of their medication in response to medical need.

67. In summary, the interventions described above are effective and safe, and access is essential for the wellbeing of those transgender adolescent patients for whom they are indicated. The treatments are provided only with assent from the patient and consent from the parent or guardian. My patients who receive medically necessary treatment for gender dysphoria often experience significant improvement in their mental health and quality of life. Medical treatment recommended for and provided to transgender adolescents with gender dysphoria can substantially reduce lifelong gender dysphoria and can eliminate the potential need for later, more invasive treatments. Access to medications to treat gender dysphoria is vital and can improve the short- and long-term health outcomes for transgender adolescents.

V. HARMS OF WITHHOLDING OR TERMINATING TREATMENT FOR TRANSGENDER ADOLESCENTS WITH GENDER DYSPHORIA

68. I have reviewed SB 150 Section 4 and I understand those rules to prohibit board-certified physicians like myself from following accepted standards of care in providing medical treatment for gender dysphoria for minors after June 29, 2023.

69. Puberty blocking medications and hormone therapies have improved the physical and mental well-being of many of my patients. Withholding this well-established, necessary medical care from patients will worsen their mental health outcomes. Being denied the only medical therapies that can legitimately treat their gender dysphoria will render their conditions more recalcitrant. Refusing medical care in this way without a sound medical basis violates my professional and ethical obligations by forcing me to withhold necessary treatment from my patients.

70. Since the passage of SB150, I have met with new patients who were candidates for puberty blocking medication and hormone therapy, but physicians, including myself, will not be permitted to prescribe them after June 29, 2023. The parents of these adolescents are angry and

concerned for their children. They want to ensure their children get the medical care they need to live happy, productive, and healthy lives. There are several families who are taking active steps to move out of Kentucky as a result. It is devastating that these parents feel that they have no other option but to leave and find a safe place for their children, who will be denied critical medical treatment if they remain in Kentucky.

71. Many of my patients who were previously mentally stable prior to SB150, have experienced increased anxiety since the passage of SB 150 because their entire focus has shifted back to what happens to them if their medical care is taken away. Additionally, many of these patients have expressed fear of being in school, fear of being erased from society, and fears about not being able to stay alive. Overall, my patients are devastated by the passage of SB 150.

72. In my clinical experience, I can attest that medications to treat gender dysphoria significantly improve the health and well-being of adolescents who are transgender patients, including developing improved relationships with their family members and peers, improved academic performance and feelings of belonging at school, the ability to develop healthy romantic relationships with their partners, and feeling hopeful about their future and the opportunities life has to offer.

73. Many of my transgender patients' anxiety, depression, suicidality and self-harming behaviors have improved following the initiation of treatment for gender dysphoria. I have witnessed myriad patients transform from being withdrawn, sullen, and unable to connect, to thriving socially, developing self-confidence, and developing close friendships. Not only have I seen this growth in my patients during our clinical visits, but many of my patients' parents have expressed to me how their child blossomed and came out of their shell after receiving treatment for gender dysphoria. Many patients' parents have expressed to me that their children improve in

school, engage more in extra-curricular clubs and activities, and laugh and smile more after starting treatment because they are no longer as preoccupied with their gender dysphoria.

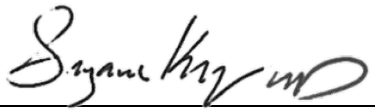
74. Many of my patients' parents have also shared with me how crippling and painful it was as a parent to watch their child struggle before receiving necessary medical care, and it haunts me to know that under SB 150, so many more parents are going to have to watch their children suffer without access to effective treatment for their gender dysphoria.

75. Transgender persons account for 0.6% of our population in the United States. This marginalized population has had the misfortune of having their medical care targeted and banned despite the existence of evidence-based medical standards that have been reviewed and adopted by major medical organizations and providers with extensive expertise in this field of medicine. As with any treatment for a minor, treatments for gender dysphoria rely on an open informed consent discussion between a qualified medical provider, their patient, and the patient's parent or guardian. There is no sound medical justification for prohibiting the medical treatment provided to this one particular population, and no basis upon which to deny parents the right to determine appropriate medical treatment for their child and to deny qualified medical providers the right to provide evidence-based treatment aligned with authoritative standards of care. The mental health disparities present in this population that are exacerbated by untreated gender dysphoria are significant and well-documented. SB 150 prohibits doctors from caring for their patients and abiding by the Hippocratic Oath.

VI. SIGNATURE

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

Executed this 22nd of May, 2023.



SUZANNE KINGERY, M.D.

Exhibit A

Curriculum Vitae

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Louisville, KY 40202
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EDUCATION

5/2000	Bachelor of Science in Biology, Davidson College, Davidson, NC
5/2005	M.D., Medical College of Georgia, Augusta, GA
6/2006	Pediatric Internship, University of Louisville, School of Medicine, Louisville, KY
6/2008	Pediatric Residency, University of Louisville, School of Medicine, Louisville, KY
7/2011	Pediatric Endocrinology Fellowship, Nationwide Children's Hospital, Columbus, OH

ACADEMIC APPOINTMENTS

8/2011 – 6/2017	Assistant Professor Pediatric Endocrinology University of Louisville, School of Medicine Louisville, KY
7/2017 – Present	Associate Professor Pediatric Endocrinology University of Louisville, School of Medicine Louisville, KY

Educational Program Leadership Positions

2016-Present	Program Director, Pediatric Endocrinology Fellowship University of Louisville, School of Medicine Department of Pediatrics Graduate Medical Education Louisville, KY
2018-Present	Course Director, Human Systems in Health and Disease 1 and 2 University of Louisville, School of Medicine Undergraduate Medicine Education Louisville, KY

CERTIFICATION AND LICENSURE

2005	National Board of Medical Examiners
2008	Diplomat, American Board of Pediatrics (ABP) – General Pediatrics
2/2008-2012	Ohio Medical License # 35.091161 (Inactive)
2011	Diplomat, American Board of Pediatrics (ABP) – Pediatric Endocrinology
6/2011	Kentucky Medical License #44436 (Active)

PROFESSIONAL MEMBERSHIPS AND ACTIVITIES

2001-2008	American Medical Association

2005-2008	Kentucky Medical Association
2005-2008	Greater Louisville Medical Society
2005-2008	Kentucky Pediatric Society
2003-present	American Academy of Pediatrics
2001-2005	American Medical Student Association, Chapter President 2002-2003
2008-2017	The Endocrine Society
2008-present	Pediatric Endocrine Society (formerly Lawson Wilkins)
2011-2017	Greater Louisville Medical Society
2013-present	American Academy of Pediatrics

HONORS AND AWARDS

2000	Cum Laude, Bachelor of Science
2000	Beta Beta Beta Biological Honor Society
2000	All-American Collegiate Award
2000	National Collegiate Natural Sciences Award
2009	Kenny Award at the Midwest Society for Pediatric Research
2009	REACH Fellows Scholarship to attend LWPES/ESPE Meeting
2009	LWPES Travel Award
2010	Clinical Fellows Travel Grants supported by Genentech
2015	Top Ten Teaching Faculty of the Year Department of Pediatrics, University of Louisville, voted by residents
2016	Top Ten Teaching Faculty of the Year Department of Pediatrics, University of Louisville, voted by residents
2016	Faculty Peer Clinician-Teacher Excellence Award for Mid-Career Faculty Department of Pediatrics, University of Louisville, voted by faculty colleagues
2016	American Medical Women's Association (AMWA) Gender Equity Award University of Louisville School of Medicine
2016	Louisville Top Doc Award Published in Louisville Magazine, voted by peers
2017	Top Five Teaching Faculty of the Year Department of Pediatrics, University of Louisville, voted by residents
2018	Top Ten Teaching Faculty of the Year Department of Pediatrics, University of Louisville, voted by residents
2018	Fitzbulter Award Humanism in Medicine University of Louisville, voted by medical students in the Gold Humanism Honor Society and Student Government Association

2018	Mid-Career Faculty Award Department of Pediatrics, University of Louisville, voted by peers
2018	Leonard Tow Humanism in Medicine Award Arnold P. Gold Foundation
2018	LGBT Center Ally Award University of Louisville School Health Sciences
2019	Faculty Peer Clinician- Teaching Excellence Award Mid-Career Faculty Award Department of Pediatrics, University of Louisville, voted by peers
2019	American Medical Women's Association (AMWA) Gender Equity Award University of Louisville School of Medicine
2020	Faculty Favorite Nominated by students as a favorite teacher at the University of Louisville
2020	Faculty Peer Clinician- Teaching Excellence Award Established Career Faculty Award Department of Pediatrics, University of Louisville, voted by peers
2021	Trailblazer Innovation Award for The eQuality Toolkit: Practical Skills for LGBTQ and DSD-Affected Patient Care Awarded by the Commercialization EPI-Center at the University of Louisville
2021	Faculty Favorite Nominated by students as a favorite teacher at the University of Louisville
2021	Outstanding Educator Faculty Excellence Awards, University of Louisville School of Medicine
2021	Student Champion Selected by students at the University of Louisville for going above and beyond my duties during the pandemic
2022	Healthcare Hero Health Equity Champion Nominee, Business First Louisville
2022	Student Champion Selected by students at the University of Louisville for going above and beyond my duties during the pandemic
2022	Golden Apple Teaching Award Selected by students in the University of Louisville School of Medicine graduating class of 2024
2023	Faculty Peer Clinician- Teaching Excellence Award Establish Faculty Award Department of Pediatrics, University of Louisville, voted by peers

COMMITTEE ASSIGNMENTS AND ADMINISTRATIVE SERVICES

Local Activities

2012 – Present	University of Louisville, School of Medicine Department of Pediatrics Pediatric Residency Program Interviewer
2012 – 2020	Norton Children's Hospital Pediatric Critical Care Advisory Committee
2013 – Present	University of Louisville, School of Medicine Department of Pediatrics Clinical Competency Committee
2014 – Present	University of Louisville, School of Medicine Department of Pediatrics Peer Mentor
2014 – 2015	University of Louisville, School of Medicine Department of Pediatrics Telemedicine Committee
2014 - 2019	University of Louisville, School of Medicine Curriculum Development eQuality Project: Integrating AAMC new guidelines for the care of LGBT and DSD-affected individuals in medical school curriculum Committee Member
2014 – Present	University of Louisville, School of Medicine Department of Pediatrics Medical Student Education Committee Member
2015	University of Louisville, School of Medicine Department of Pediatrics Summer Externship Sub-Committee Member
2015 – 2019	University of Louisville Physicians Health Sciences Campus LGBTQ Working Group
2016 - 2022	University of Louisville, School of Medicine Department of Pediatrics Resident and Faculty Wellness Committee
2017-Present	University of Louisville, School of Medicine Undergraduate Medical Education M1-M2 Sub-Committee
2017-Present	University of Louisville, School of Medicine Department of Pediatrics Diversity and Inclusion Committee

2018—Present	University of Louisville, School of Medicine Department of Pediatrics Promotion and Tenure (PAT) Committee
2019- 2021	University of Louisville, School of Medicine Undergraduate Medical Education LCME Basic Sciences Committee
2019-2020	University of Louisville, School of Medicine Undergraduate Medical Education Undergraduate Medical Education (UME) Assessment Committee
2019, 2021-2022	University of Louisville, School of Medicine School of Medicine Celebration of Faculty Excellence Educator Awards Selection Committee
2019-2021	University of Louisville, School of Medicine Strategic Planning Committee Undergraduate Medical Education (UME) Subgroup
2020-Present	University of Louisville, School of Medicine Undergraduate Medical Education Educational Program Committee (EPC)
2020-Present	University of Louisville, School of Medicine Undergraduate Medical Education Academic Technology Subcommittee (ATS)
2020-Present	Norton Children's Medical Group Executive Medical Council
2020-Present	Norton Children's Medical Group Clinical Leadership Council
2021-2023	Norton Children's Hospital Medical Executive Committee

Regional Involvement

2014 – 2016	American Academy of Pediatrics, Kentucky Chapter Obesity Task Force
2015 – 2017	YMCA of Greater Louisville Diabetes Prevention Program Steering Committee
2015 – 2018	YMCA of Greater Louisville Heathy Weight and Your Child
2015 – 2018	Region 4 Newborn Screening Collaborative Congenital Hypothyroidism Follow-up Program

Endocrine Lead

National Activities

2015 – 2019 Association of American Medical Colleges
Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development
Member, Axis Committee

2020 – Present American Board of Pediatrics
Member, Endocrinology Subboard

2021 – Present ScholarRx Faculty Advisor
USMLE Step Series Educational Resource
Qmax question back and Bricks

EDUCATIONAL ACTIVITIES

Educational Positions

Local/Regional

2012 – Present Medical Education - Division of Endocrinology
Department of Pediatrics, University of Louisville
Divisional Medical Education Director
Our Elective service averages 40-50 students/residents/fellows that I supervised annually. They follow a scheduled curriculum which includes an inpatient and outpatient experience, weekly lectures and study assignments. This experience includes direct patient evaluation and management as well as additional nutrition and diabetes education teaching sessions.

2015 - Present University of Louisville, School of Medicine
Undergraduate Medical Education
Endocrinology Clinical Lead Thread Director
Responsible for the developing the endocrinology curriculum for the 2nd year medical students within the School of Medicine. This involves directing lectureships, team based learning (TBL), problem based learning (PBL), teaching material, providing endocrine lectures, and assessment of all material for both individual and team based learning assignments and with final multiple choice examination.

2016-Present University of Louisville, School of Medicine
Department of Pediatrics
Graduate Medical Education
Pediatric Endocrinology Fellowship Director
Designed, developed, and submitted application an ACGME approved pediatric endocrinology fellowship which received initial accreditation in April 2017 and continued accreditation in September 2021. Direct, supervise and participate in all aspect of fellow education, assessment and evaluation in compliance with ACGME guidelines. Program is approved for 3 total positions, and have filled all 3 fellowship positions, 1 per year for the 3 year program.

2017-Present University of Louisville, School of Medicine

Undergraduate Medical Education
Problem Based Learning (PBL) Instructor
Mentor medical students in year one and year two during PBL case discussions throughout the semester. Facilitate and monitor the discussion and interactions and gently guide students to involve each other more deeply in the conversation, ask each other questions, and give each other feedback. Each session runs approximately two hours for a total of 10 sessions each semester.

2018-2022 University of Louisville, School of Medicine
Undergraduate Medical Education
Humanism and Compassion in Medicine (HCM) Instructor formerly named Interdisciplinary Clinical Conference (ICC)
Mentor medical students in year one and year two during HCM sessions throughout the semester. Facilitate, monitor, and provide feedback on verbal case presentations, patient interview skills, assess challenges in ethics, patient communication, culture and diversity, and explore real work issues of translating classroom information to clinical practice. Each session lasts for a total of two hours for a total of 4-5 sessions a semester.

2018-Present University of Louisville, School of Medicine
Undergraduate Medicine Education
Course Director, Human Systems in Health and Disease 1 and 2
Direct all faculty, teaching, and assessments for these two very large, 15-to 18-credit hour courses required of all second year medical students. Courses that encompass the foundational Physiology, Histology, Pharmacology, Microbiology, Pathology, Pathophysiology of the major body systems, spanning the second year of the MD program. Nearly 100 clinical and basic science teaching faculty from twelve departments participate in teaching these major courses under my leadership and direction as course director. Multiple forms of teaching are used, including lecture, flipped classrooms, Team-Based Learning (TBL), Problem-Based Learning (PBL), simulation, and patient interviews

2021-2022 Norton Children's and University of Louisville
Norton Children's Endocrinology
Course Director, Wendy Novak Diabetes Symposium
Organize, plan, and implement the annual diabetes symposium in collaboration with Norton Healthcare Continuing Medical Education. In this role, I oversee the planning committee and participate identifying topics and presenters for this educational event. I am responsible for submitting for CME credit, confirming presenter available and coordinating the symposium's schedule of events.

National/Regional Meetings - Invited Lectureships

2012 Pediatric Grand Rounds, University of Louisville: Turner Syndrome Update
2012 OB/GYN Grand Rounds, University of Louisville: Care of Women and Girls with Turner Syndrome
2013 Pediatric Surgery Grand Rounds, University of Louisville: Multiple Endocrine Neoplasia
2013 Endocrine Grand Rounds, University of Louisville: Turner Syndrome: The X Factor

2013 JDRF 2nd Annual Diabetes Conference, Muhammad Ali Center: Sports Care Management and Nutrition
JDRF 2nd Annual Diabetes Conference, Muhammad Ali Center: Diabetes and the School System

	JDRF 2nd Annual Diabetes Conference, Muhammad Ali Center: Parents Dealing with Child's Diabetes
2015	JDRF Summit, Bellarmine University: Teens and Diabetes
2015	Pediatric Grand Rounds, University of Louisville: Gender Non-conforming Youth
2016	Kentucky Perinatal Association Annual Meeting, Lake Cumberland KY: Ambiguous Genitalia and Disorders of Sexual Development
2016	Endocrine Grand Rounds, University of Louisville: Gender Variant and Gender Dysphoric Youth
2017	Ob/Gyn Grand Rounds, University of Louisville: What I wish I knew when caring for LGBTQ patients
2018	JDRF Summit, Louisville KY: Diabetes Burnout
2018	American Academy of Pediatrics, Kentucky Chapter, Annual Meeting, Berea KY: Understanding Children and Adolescents with Gender Dysphoria
2018	Staying Alive Kentucky 2018: Building Youth for the Future, Lexington KY: TRANSformative Healthcare: Gender Expansive and Transgender Adolescents
2018	Pediatric Behavioral and Mental Health Symposium: Addressing Mental Health Disparities in Diverse Populations, Louisville, KY: Complex Cases: Ethics, Diversity and Legal Issues in Transgender Care
2018	Family Medicine Grand Rounds, University of Louisville: TRANSformative Healthcare: Gender Expansive Youth and the Role of the Primary Care Provider
2019	Just for Kids-Norton Healthcare Pediatric Symposium, Louisville KY: Endocrine Short Stature
2019	Wendy Novak Diabetes Symposium, University of Louisville: Type 1 Diabetes, Type 2 Diabetes and Beyond!
2019	Undergraduate Medical Education Faculty Development Series, University of Louisville: Evidence-Based Care of LGBTQ Patients Using The eQuality Toolkit
2019	LGBTQ Health Certificate Series, University of Louisville: Variations in Sex Development and Intersex Conditions: Shifting Paradigms
2020	Undergraduate Medical Education Faculty Development Series, University of Louisville: Dismantling White Supremacy and Undoing Race Based Medicine in ULSOM Undergraduate Medical Education Curriculum
2022	Pediatric Grand Rounds, LSU and Oshner Children's Hospital: Gender Dysphoria
2022	AAP Advocacy Conference, Virtual Meeting: Advocacy for Pediatric Subspecialists-Leveraging Your Expertise
2022	Just For Kids-Norton Healthcare Pediatric Symposium, Louisville, KY: Creating an Inclusive Environment for LGBTQ+ patients
2022	Norton Healthcare and Bellarmine University Pelvic Health Symposium, Louisville, KY: Gender Affirming Healthcare for Pelvic Floor Providers
2022	Norton Primary Care Symposium, Louisville, KY: Monitoring for Adverse Effects of Gender Affirming Hormone Therapies
2022	Pediatric Behavioral and Mental Health Symposium, Louisville, KY: LGBTQ+ Youth: The Impact on Pediatric Mental Health

Local/Regional – Health Care Professional Lectures

2009	Nurses Education Day, Nationwide Children's Hospital, Columbus OH: Diabetes and Electrolyte Management
2009 – 2011	Nurses Quarterly CME Series, Nationwide Children's Hospital, Columbus OH: Diabetes and Diabetes During Times of Stress
2012	General Pediatric Division Lectureship, University of Louisville: Precocious Puberty
2012	Endocrine Grand Rounds, University of Louisville: Gene CNVs and protein

	levels of complement C4A and C4B as novel biomarkers for partial disease remissions in new onset type 1 diabetes patients
2014	Pediatric Hospitalist Lectureship, University of Louisville: Hypoglycemia in the Pediatric Patient
2014	LGBTQ Health Certificate Series Session, University of Louisville: LBGT-affirming Care panel expert
2015	Endocrine Grand Rounds, University of Louisville: Hypoglycemia in Childhood
2015	PICU Nurse Lectureship, March Potpourri, University of Louisville: DKA
2016	Child and Adolescent Psychology Lectureship, University of Louisville: Differences in Sex Development for the Psychologist
2016	LGBTQ Health Summit, University of Louisville: Transgender Hormone Protocols
2019	Norton Healthcare Nursing Grand Rounds, Norton Children's Hospital: TransCare 101
2021	Norton Prevention and Wellness, Louisville, KY: Let's Talk: Caring for the LGBTQ Child
2021	Norton NPRIDE and PAGE Webinar, Louisville, KY: Introduction to Gender Identity
2021	Norton NPRIDE and PAGE Webinar, Louisville, KY: Mental Health in Transgender Youth
2021	Norton NPRIDE and PAGE Webinar, Louisville, KY: Navigating the Real World with Transgender Youth
2021	Grow502 Health Disparities Series, Louisville, KY: Digging Deeper into Diabetes
2022	Child and Adolescent Psychology Lectureship, University of Louisville: Medical Aspects of Transgender Care
2022	Norton Healthcare NPRIDE Webinar, Louisville, KY: Wellness in the LGBTQ+ Youth Community
2022	Transgender Wellness Summit, Louisville, KY: Youth Gender Affirming Hormone Therapy
2023	LGBTQ Health Certificate Series, University of Louisville: Providing LGBTQ+ Affirming Healthcare in Difficult Climates
2023	LGBT Center and Office of Diversity & Inclusion, University of Louisville: The State of Gender Affirming Healthcare in Kentucky
2023	Transgender Wellness Summit, Louisville, KY: The Truth about Gender Affirming Hormone Therapy

Local-Resident/Student Lectures

2008 –2011	Pediatric Resident/Student Lecture, Nationwide Children's Hospital: Metabolic Bone Disease in Children Resident/Student Lecture, Nationwide Children's Hospital: Thyroid Disorders in Children Resident/Student Lecture, Nationwide Children's Hospital: Congenital Adrenal Hyperplasia Pediatric Resident/Student Lecture, Nationwide Children's Hospital: Adrenal Crisis Resident/Student Lecture, Nationwide Children's Hospital: Precocious Puberty Pediatric Resident/Student Lecture, Nationwide Children's Hospital: Hypoglycemia in Infants and Children Pediatric Resident/Student Lecture, Nationwide Children's Hospital: Growth Disorders in Children
2012	Pediatric Neonatology Fellow Lecture, University of Louisville: Thyroid Disorders in Neonates
2012 - 2013	First Year Medical Student Lecture, University of Louisville: Interdisciplinary Clinical Cases: Diabetes Mellitus
2013 -Present	Pediatric Resident Lecture, University of Louisville: Obesity, Type 2 Diabetes Mellitus and Metabolic Syndrome in Pediatrics
2013 -Present	Pediatric Resident Lecture, University of Louisville: Thyroid and Adrenal Disorders in Infants, Children, and Adolescents

2013 –2018	3rd – Year Medical Student Core Lecture Series, University of Louisville: General Pediatric Endocrine Disorders (every 6 week lecture)
2014 -Present	4th-Year Medical Student Practical Pediatrics Course, University of Louisville: DKA
2015 -Present	1st- year Medical Student Core Lecture, University of Louisville: Differences of Sex Development
2015 -Present	1st year Medical Student Core Lecture, University of Louisville: Differences of Sex Development Patient Panel
2016 -Present	2nd year Medical Student Core Lecture, University of Louisville: Cross Gender Hormone Therapy
2016 -Present	2nd year Medical Student Core Lecture, University of Louisville: Overview of the Pituitary Gland Disorders
2016 -Present	2nd year Medical Student Core Lecture, University of Louisville: Thyroid Disorders and Thyroid Cancers
2016 -Present	2nd year Medical Student Core Lecture, University of Louisville: Calcium and Bone Homeostasis
2016 -2019	2nd year Medical Student Core Lecture, University of Louisville: Child and Adolescent Sexuality
2016 –Present	Pediatric Resident Lecture, University of Louisville: Gender Variant and Gender Dysphoria Youth
2017 -Present	2nd year Medical Student Core Lecture, University of Louisville: Agents Affecting Bone Mineralization SoftChalk
2017	Medicine/Pediatric Resident Lecture, University of Louisville: Pediatric Obesity
2018-Present	2nd year Medical Student Core Lecture, University of Louisville: Type 1 Diabetes Mellitus and Insulin Therapies
2018, 2021	2nd year Medical Student Core Lecture, University of Louisville: Type 2 Diabetes Mellitus
2018-Present	4th year Medical Student Practical Pediatrics Course, University of Louisville: Endocrine Emergencies
2018-Present	2nd year Medical Student Core Lecture, University of Louisville: Overview of Diabetes Mellitus SoftChalk
2018	Pediatric Neonatology Fellow Lecture, University of Louisville: Differences in Sexual Differentiation, a Multidisciplinary Approach
2018-Present	2nd year Medical Student Core Lecture, University of Louisville: Insulin Management and Applications
2018-Present	2nd year Medical Student Core Lecture, University of Louisville: Medications for the Treatment of Type 2 Diabetes Mellitus SoftChalk
2018	Educational Core Conference, Division of Pediatric Endocrinology, University of Louisville: DSDs: A Patient Centered Paradigm
2019- Present	2nd year Medical Student Core Lecture, University of Louisville: Adrenal Axis Disorders
2020-Present	2nd year Medical Student Core Lecture, University of Louisville: Sleep Disorders SoftChalk
2020-Present	2nd year Medical Student Core Lecture, University of Louisville: Sexuality Over a Lifespan SoftChalk
2020-Present	2nd year Medical Student Core Lecture, University of Louisville: NSAIDs, Analgesics and Anti-Inflammatory Medications SoftChalk
2020, 2022	Pediatric Resident Lecture, University of Louisville: Communicating with LGBTQ Patients and their Families
2021	Educational Core Conference, Division of Pediatric Endocrinology, University of Louisville: DSDs: Hypothalamic Pituitary Hormones, Storage, Regulation and Disorders
2021-Present	2nd year Medical Student Core Lecture, University of Louisville: Oxytocics and Tocolytics SoftChalk
2021	Pediatric Neonatal Intensive Care Fellows Lecture, University of Louisville: A Neonatologist's Guide to DSDs and Intersex Conditions

2021	LGBTQ Medical Student Interest Group, University of Louisville: Improving the Mental Health of Youth with Gender Dysphoria
2022	Educational Core Conference, Division of Pediatric Endocrinology, University of Louisville: Congenital Adrenal Hyperplasia
2023	Psychiatry Resident Lecture, University of Louisville: Gender Affirming Hormone Therapy

Advising and Mentoring

Students

2015-2018 — Adam Neff, MS2-MS4, University of Louisville School of Medicine. Distinction in Medical Education (DIME) track. With my mentorship, he developed a Problem Based Learning (PBL) module on Androgen Insensitivity Syndrome, created evaluation tools to assess effectiveness of the PBL, and implemented the PBL as part of the integrated LGBTQ and DSD curriculum. The PBL focused on gender identity, sexual orientation, and differences in sexual development. Our PBL with evaluation tools and data collected on effectiveness was published on the MedEd Portal. Additionally, several abstracts were presented at nationally meetings, including the *International Meeting of Pediatric Endocrinology* and *Gay and Lesbian Medical Alliance (GLMA).*

2017 – 2020 — Destiny Duvall, MS2-MS4, University of Louisville School of Medicine. Distinction in Medical Education (DIME) track. With my mentorship, she developed on-line learning modules in SoftChalk for housestaff regarding differences in sex differentiation, gender identity and sexual orientation. In additional to developing the SoftChalk curricula, she also developed evaluation tools to assess the effectiveness of these learning modules for housestaff in different fields of medicine, including pediatrics, internal medicine, surgery, and ob/gyn.

2017- 2018 — Lauren Logan, MS3-MS4, University of Louisville School of Medicine. With my mentorship, she wrote, revised and submitted a case report for Index of Suspicion which was published in *Pediatrics in Review*.

Residents

2013-2014 — Prasanthi Pasala, PGY3, University of Louisville Department of Pediatrics. With my mentorship, she developed and completed and quality improvement project regarding thyroid function tests obtained in the NICU on premature infants. This scholarly project effectively decreased the labs obtained on the premature infants which is more cost effective. Finding were presented as an abstract and poster presentation at the pediatric resident awards day.

2016 - 2018 — Shanna Sharber, PGY2-PGY3, University of Louisville Department of Pediatrics. With my mentorship, she created an IRB approved scholarly project to assess the knowledge, comfort and experience of pediatric trainees regarding gender non-conforming and transgender youth in a primary care setting. Finding were collected and analyzed and abstract and poster presented at the University of Louisville Department of Pediatrics Poster Day.

2017 – 2019 — Courtney Sumner, PGY3, University of Louisville Department of Pediatrics. With my mentorship, she created an on-line, interactive learning module on gender non-conforming and transgender youth during SoftChalk curricula. Following IRB approval, these modules were implemented by during an adolescent medicine and endocrinology rotation and the effectiveness of this learning module were assessed formally. Finding

were collected and analyzed and abstract and poster presented at the University of Louisville Department of Pediatrics Poster Day.

2018- 2020 — Jeremy Brown, PGY2-PGY3, University of Louisville Department of Pediatrics. Mentoring a retrospective study on CGM use in patients with type 1 diabetes mellitus, hospital admissions, and demographics. Following IRB approval, data collected from chart reviews. Finding were collected and analyzed and abstract and poster presented at the University of Louisville Department of Pediatrics Poster Day.

2018-2020 — Katie Bruenger, PGY2-PGY3, University of Louisville Department of Pediatrics. Mentoring a prospective study using quality of life metrics to evaluate psychological comorbidities in transgender youth undergoing gender affirming therapies. Following IRB approval, patients were consented and data collected from surveys. Finding were collected and analyzed and abstract and poster presented at the University of Louisville Department of Pediatrics Poster Day.

CLINICAL ACTIVITIES

DIRECT CLINICAL SERVICE AND LEADERSHIP ACTIVITIES

2011 – Present — **Pediatric Endocrinology Attending - Hospital/Call Service:**
Provide endocrinology consultation and admitting patient care service for hospitalized children, and 24 hour pager call service for patients, physicians, and hospital staff. Inpatient admitting and consultation services are provided at Norton Children's Hospital with additional consultation services provided to Norton/Norton Suburban Hospital, and University of Louisville Hospital. (1 week/12 weeks).

2011 – Present — **Outpatient Clinic Service**
Provide endocrinology consultation/referral/on-going outpatient patient care on Tuesdays of each week at the 601 South Floyd Street office Louisville, KY (2 clinics/week).

Additional Duties to improve clinical service:

- *Outpatient Medical Observation Unit (OMO): Assisted in updating testing and treatment protocols/order sets used in OMO (Growth Hormone Stimulation Testing, ACTH Stimulation Test, Pamidronate Infusion Order Set).*

Additional Clinical Duties*: Medical records management, patient/family/physician phone call communications. Approximately 5-10 patient related phone contacts/day while fulfilling clinical duties.*

2011 – 2013 — **Physician Champion/Endocrine Lead, Electronic Health Record/Allscripts Liaison, Louisville, KY**
Championed the division's go-live on Allscripts EHR, creating templates for new patients, follow-up patients, and diabetes patients. Also served as a resource for the division for questions and concerns, and acted as the liaison between Allscripts developers and members of the division.

2011 – 2017 — **University of Louisville, Children's Metabolic Bone Center, Louisville, KY**
Associate Director

Multi-disciplinary clinical effort in conjunction with Dr. Kupper Wintergerst from Pediatric Endocrinology and Dr. Laura Jacks from Norton Healthcare, Pediatric Orthopedic Surgery. This clinic specializes in the care of children with nutritional, metabolic, and genetic bone disease and is located at Old Brownsboro Crossing in Louisville, KY

2012-Present **Physician Champion/Endocrine Lead, Electronic Health Record/ EPIC Liaison, Louisville, KY**
Championed the division's go-live on EPIC EHR, creating templates for inpatient consultations and follow-up notes as well as creating smartphrases. Created order sets for outpatient medical observations procedures as well as inpatient admission orders. Also served as a resource for the division for questions and concerns, and acted as the liaison between EPIC developers and members of the division.

2014 – 2019 **Wendy Novak Diabetes Care Center, Diabetes Adherence Resource Team (DART) Clinic, Louisville, KY**
Director
Multi-disciplinary clinical effort comprised of a pediatric endocrinologist, diabetes nurse practitioner, certified diabetes educator, dietician and pediatric psychologist. This multi-disciplinary clinic allows for more comprehensive management of high risk patients with type 1 diabetes who often face a number of obstacles and challenges in their disease management. DART clinic is offered 2 mornings a month at the Wendy Novak Diabetes Care Center in Louisville, KY.

2015 – Present **Norton Children's Pediatric Endocrinology Pediatric and Adolescent Gender Education (PAGE) Program, Louisville, KY**
Director
Direct the DSD and transgender clinic within the division of endocrinology and also direct the multi-disciplinary clinical effort in conjunction with University of Louisville pediatric psychologist. This clinic specializes in the care of infants, children, and adolescents born with a disorder of sexual development as well as youth who are gender nonconforming, gender diverse or transgender. This clinic is offered 1 day each week in Louisville, KY.

2016 – Present **Norton Children's Pediatric Endocrinology, Louisville, KY**
Medical Director, General Pediatric Endocrinology with University of Louisville
Responsible for all operational aspects of clinical pediatrics endocrinology services, from clinic flow, organization, scheduling, staffing, and EHR for improved efficiencies and RVU generation. I also direct all mid-level providers in the division and evaluate their performance. Additionally, work to implement new processes such as centralized scheduling, and ensure providers are meeting certain metrics, both billing and meaningful use. I work closely with both the practice manager and division chief of endocrinology to increase functionality and satisfaction of both patients and providers.

GRANTS AND CONTRACTS

Past Clinical Trials

1. **Increlex Growth Forum Database – IGFD Registry**
   Past, OICN070695
   Ispen Biopharmaceuticals (a company formerly named Tercica, Inc.)
   $5,000.00, **Direct:** 3,700.00, **Indirect:** 1,300.00
   Co-I, 1% Effort, 10% Collaboration

04/2007 – 04/2015

2. **A Randomized, Multi-Center, Parallel Group, Single-Dose, Pharmacokinetics and Pharmacodynamics Study of Dapaglifozin in Children and Adolescents Aged 10 to 17 Years With Type 2 Diabetes Mellitus**
   Past; NCT02325206; Account Active
   Parexel International Corporation, OICN121519
   $49,551.00 Direct: $39,326.00, Indirect: $10,225.00
   Co-I, 1% Effort, 50% Collaboration
   11/2012 – 01/2015

3. **A multicenter, observational study of pediatric female patients with Central Precocious Puberty receiving SUPPRELIN® LA (histrelin acetate), a hydrogel subcutaneous implant Short Title: CCP Patient Registry**
   Past, OICN120128
   OICN120128
   $192,325, **Direct:** $152,639, **Indirect:** $39,686
   Co-I, 1% Effort, 25% Collaboration.
   9/2011 – 09/2016

4. **B9R-EW-GDFC(b)**
   Past
   Eli Lilly, Inc., GRNT030163
   $163,127.00, **Direct:** $123,976.52, **Indirect:** $39,150.48
   Co-I, 1% Effort, 10% Collaboration
   08/2002 – 06/2016

5. **NNPI/Norditropin National Registry Program**
   Past
   Novo Nordisk Pharmaceuticals, Inc., GRNT021068
   $84,912.00, **Direct:** $64,702.4, **Indirect:** $20,209.06
   Co-I, 1% Effort, 10% Collaboration
   03/2002 – 05/2016

6. **A Phase IV, Multicenter, Open-Label Study of the Immunogencity of Nutropin AQ V1.1 [Somatropin (rDNA Origin) Injection] Administered Daily to Maive Growth Hormone-Deficient Children**
   Past; NCT02311894
   Genentech, Inc., CCDN160120
   $40,620, Direct: $32,238, Indirect: $8,382
   Co-I, 1% Effort, 5% Collaboration
   9/2015 – 9/2017

7. **Validation of two measures for growth hormone deficiency in children, the Treatment Related Impact Measure of Childhood Growth Hormone Deficiency (TRIM-CGHD) and the Treatment Burden Measure of Childhood Growth Hormone Deficiency (TB-CGHD)**
   Past
   Novo Nordisk Pharmaceuticals, Inc.
   $11,250, Direct: $8,929 Indirect: $2,321
   PI, 1% Effort, 85% Collaboration
   03/25/2016 – 12/31/2017

8. **Post-Approval Safety Study (PASS) to Monitor the Long-term Safety and Efficacy of Omnitrope® in**

Infants, Children and Adolescents (Observation Plan: EP00-501)
Past
Sandoz Inc.
$84,365.60, **Direct:** $66,956.83, **Indirect:** $17,408.77
Co-I, 1% Effort, 10% Collaboration
12/2012 – 04/2018

9. **Louisville Metro LGBT Healthcare Survey**
   Past
   Investigator Initiated, Unfunded
   PI, 1% Effort
   9/2016-5/2018

10. **SIMPONI® to Arrest β-cell Loss in Type 1 Diabetes – A Phase 2 Study**
    Past; NCT02846545
    Janssen Research & Development, LLC, CCDN161110
    Co-I, 1% Effort, 45% Collaboration
    $90,389.00; Direct: $71,738.00 Indirect: $18,651.00
    8/2016 – 8/2018

11. **Hyperglycemic Control in Critically Ill Children**
    Past
    Investigator Initiated QA, Unfunded
    Diabetes Control in a Pediatric Diabetes Clinic
    Co-I, 1% Effort
    12/20011 – 11/2018

12. **TN-18 CTLA-4 (Abatacept) for Prevention of Abnormal glucose Tolerance and Diabetes in Relatives At-Risk for Type 1 Diabetes Mellitus**
    Past; NCT01773707
    University of South Florida/NIH, CCDN151441
    $98,003, Direct: $77,780, Indirect: $20,223
    Co-I, 1% Effort, 10% Collaboration
    12/23/2015 – 03/30/2019

13. **A Multicenter, Randomized, Partial-Blinded, Placebo-Controlled Study to Evaluate the Safety and Efficacy of a Human Plasma-Derived Alpha1-Proteinase Inhibitor in Subjects with New-Onset Type 1 Diabetes Mellitus**
    Past; NCT02093221
    Grifols Therapeutics, Inc., OICN140565
    $461,686, Direct: $366,417, Indirect: $95,269
    C0-I, 1% Effort
    5/2014-5/2019

14. **eQuality: Leading Medical Education to Deliver Equitable Quality Care for all People, Regardless of Identity, Development, or Expression of Gender/Sex/Sexuality**
    Past
    Investigator Initiated, Unfunded
    Co-PI, 1% Effort
    1/2016-3/2020

15. **Assessing Pediatric Residents' Training and Confidence In Caring For Children Presenting With Gender Dysphoria In A Primary Care Setting**
    Past
    Investigator Initiated, Unfunded
    PI, 1% Effort
    4/2017-7/2020

16. **Evaluating Use of Continuous Glucose Monitoring and Its Effect on Hospital Admissions**
    Past
    Investigator Initiated, Unfunded
    PI, 1% Effort
    8/2019-7/2020

17. **TransCon hGH CT-301 Admin Once a Week Vs Standard Daily**
    Past
    Premier Research Group, CCDN170215
    PI, 1% Effort, 50% Collaboration
    $136,742, Direct: $108,525; Indirect: $28,217
    8/2017-8/2022

18. **IAA- Hybrid Closed Loop Insulin Delivery System Data Collection (HYCLO)**
    Past
    Jaeb Center for Health Research, CCDN180816
    PI, 1% Effort, 85% Collaboration
    $4,125, Direct; $3,750; Indirect: $375
    1/2018-12/2019

19. **TN-20 Exploring Immune Effects of Oral Insulin in Relatives at Risk for Type 1 Diabetes Mellitus**
    Past; NCT0258077
    University of South Florida/NIH, CCDN160338
    $13,600, Direct: $10,794, Indirect: $2,806
    Co-I, 1% Effort, 70% Collaboration
    12/2014 – 06/2017

20. **A Randomized Clinical Trial to Assess the Efficacy and Safety of Continuous Glucose Monitoring in Youth < 8 with Type 1 Diabetes: Strategies to Enhance New CGM use in Early childhood (SENCE)**
    Past; (NCT02912728
    Indiana University, CCN161481 & CCDB161481
    Co-I, 1% Effort, 50% Collaboration
    $232,500, Direct: $184,524; Indirect: $47,976
    07/2016 – 05/2018

21. **A Phase 3, Double-Blind, Placebo-Controlled, Randomized, Multi-Center Study To Assess The Safety And Efficacy Of Exenatide Once Weekly In Adolescents With Type 2 Diabetes**
    Past; NCT01554618
    AstraZeneca LP, CCDN 161293
    Co-I, 1% Effort, 5% Collaboration
    $15,608, Direct: $12,387, Indirect: $3,221
    08/2016 – 08/2021

22. **A study to Assess Continuous Glucose Sensor Profiles in Healthy Non-Diabetic Subjects**
    Past

Jaeb Center for Health Research, CCDN171314
Co-PI, 1% Effort, 25% Collaboration
$20,213, Direct: $18,375; Indirect: $1,838
6/2017 – 1/31/2018

CONTRACTS

Current

1. **T1D Exchange Type 1 Diabetes Network**
   Current (Closed to Enrollment)
   Jaeb Center for Health Research, CCDN151043
   $419,250, Direct: $381,136, Indirect: $38,114
   Co-I, 1% Effort, 5% Collaboration
   7/2015 – 3/2016

CLINICAL TRIALS

1. **TN-01 TrialNet Natural History Study of the Development of Type 1 Diabetes**
   Current; NCT00097292
   University of South Florida/NIH, OICN111097
   $286,971, Direct: $227,755 Indirect: $59,216
   Co-I, 1% Effort, 80% Collaboration
   06/2011 – 06/2018

2. **Zinc and Nutrient Deficiency in Children with Diabetes Mellitus**
   Current
   Investigator Initiated, Unfunded
   Co-PI, 1% Effort
   3/2017-Present

3. **A double-blind, randomised, placebo-controlled, parallel group trial to evaluate the efficacy and safety of empagliflozin and linagliptin over 26 weeks, with a double-blind active treatment safety extension period up to 52 weeks, in children and adolescents with type 2 diabetes mellitus Di**abetes study of li**N**Agliptin and e**M**pagliflozin in children and ad**O**lescents (**DINAMO**)
   Current; NCT03429543
   Boehringer Ingelheim, CCDN161072
   Sub-I, 1% Effort, 25% Collaboration
   $69,503, Direct: $63,185; Indirect: $6,319
   09/2018 – 03/2022

4. **TN22 - Hydroxychloroquine For Prevention Of Abnormal Glucose Tolerance And Diabetes In Individuals At-Risk For Type 1 Diabetes Mellitus**
   Current; NCT03428945
   University of South Florida/NIH, CCDN190267
   Co-I, 1% Effort, 70% Collaboration
   $10,205, Direct: $8,099; Indirect: $2,106
   07/01/2018 – 06/30/2022

5. **Quality of life and psychological comorbidities in youth with gender dysphoria**

Current
Investigator Initiated, Unfunded
PI, 1% Effort
9/2019-Present

6. **Effects of Prescribed Cross Gender Hormone Therapy on Maximal Rate of Oxygen Consumption**
Current
Investigator Initiated, Unfunded
PI, 1% Effort
1/2020-Present

EDITORIAL WORK

Ad hoc Reviewer

2013	*Journal of Adolescent Health*
2014-Present	Pediatric Academic Society Annual Meeting Abstract Reviewer
2015-Present	*Current Diabetes Reviews*
2017	International Meeting of Pediatric Endocrinology Abstract Reviewer
2017-Present	*Translational Pediatrics*
2020	*Teaching and Learning in Medicine*
2020	Pediatric Academic Society Annual Meeting Workshop Reviewer

ABSTRACTS AND PRESENTATIONS

ORAL PRESENTATIONS

Local/Regional Meetings

1. Type 1 diabetes, HLA, Complement and Gene Copy Number Variation. Presented translational component at Bench to Outcomes Seminar Series, Columbus OH, December 2008

National/International Meetings

1. **Kingery SE**. Lower Complement C4 Gene Copy Number is a Genetic Risk Factor for Type 1 Diabetes Mellitus in Pediatric Patients. Midwest Society of Pediatric Research, Chicago IL, October 2009

2. Weingartner L, Holthouser A, Noonan E, **Kingery SE**, Potter J, Shaw MA, Sawning S. Direct Practice with Medical Students to Develop LGBTQ Clinical Skills and Identify Barriers to Implementation. Southern Group on Educational Affairs (SGEA) Conference. Orlando, FL, March 2019.

3. Weingartner L, Noonan E, Sawning S, **Kingery SE**, Holthouser A. Teaching Specific LGBTQ Clinical Skills Using The eQuality Toolkit. Workshop. Southern Group on Educational Affairs (SGEA) Conference. Orlando, FL, March 2019. ***2019 MESA Award winner in the category Outstanding Presentation Award for Undergraduate Medical Education (UME)**

4. Weingartner L, Noonan E, Holthouser A, **Kingery SE**, Sawning S. Toolkit LGBTQ Clinical Skills Workshop. AAMC Central and Southern Group on Student Affairs/Organization of Student Representatives Joint Regional Spring Meeting. Louisville, KY, April 2019.

5. Weingartner L, Noonan E, Holthouser A, Potter J, Steinbock S, Bohnert C, **Kingery SE**, Sawning S. Developing Clinical Skills for LGBTQ Patient Care with Direct Practice. Oral Presentation at the LGBT Health Workforce Conference. New York, NY, May 2019.

6. Weingartner L, Noonan E, Holthouser A, Potter J, Bohnert C, **Kingery SE**, Sawning S. Teaching and Assessing LGBTQ Clinical Skills with The eQuality Toolkit. Workshop at the Association of American Medical Colleges (AAMC) Meeting. Phoenix, AZ, November 2019.

Posters

Local/Regional Meetings

1. Akintola KO, Omoruyi AO, Foster MB, **Kingery SE**, Wintergerst KA. Behavioral Disorders associated with GnRH agonist therapy. Abstract/Poster Presentation. University of Louisville, Pediatric Grand Rounds, Louisville KY, June 2013.

2. Pasala P, **Kingery SE.** Evaluation of Congenital Hypothyroidism Screening Infants at Kosair Children's Hospital NICU. Abstract/Poster Presentation. University of Louisville, Pediatric Grand Rounds, Louisville KY, June 2014.

3. Myers WT, **Kingery SE**, Foster MB, Wintergerst KA. Sudden Generalized Edema in a 15 year-old diabetic girl. Abstract/Poster Presentation. University of Louisville, Pediatric Grand Rounds, Louisville KY, June 2015.

4. Sharber S, **Kingery SE**. Assessing a pediatric residency program's training and confidence in caring for children presenting with gender dysphoria in a primary care setting. Abstract/Poster Presentation. University of Louisville, Pediatric Grand Rounds, Louisville KY, June 2018

5. Sumner C, **Kingery SE**. Improving a Pediatric Residency Program's Training and Confidence in Caring for Children Presenting with Gender Dysphoria in a Primary Care Setting. Abstract/Poster Presentation. University of Louisville, Pediatric Grand Rounds, Louisville KY, June 2019.

6. Bruenger K, **Kingery SE.** Quality of Life and Psychological Comorbidities in Youth with Gender Dysphoria. Abstract/Poster Presentation. University of Louisville, Pediatric Grand Rounds, Louisville KY, June 2020.

7. Brown J, **Kingery SE**. The Effect of Continuous Glucose Monitoring on Admissions for Diabetic Ketoacidosis. Abstract/Poster Presentation. University of Louisville, Pediatric Grand Rounds, Louisville KY, June 2020.

National/International Meetings

1. **Kingery SE**, Wu YL, Yang Z, Chung EK, Zipf W, Germak JA, Hoffman RP, Yu CY. Monomodular RP-C4-CYP21-TNX (RCCX) Haplotype with a Short Gene for Complement C4B is a Genetic Risk Factor for Type 1 Diabetes Mellitus with the Age of Onset Modified by C4A Gene Copy Number Variation. American Diabetes Association Annual Scientific Meeting, New Orleans LA, June 200. *Diabetes*. 2009; 58 (Suppl 1)

2. **Kingery SE**, Wu YL, Zhou B, Hoffman RP, and Yu CY. Lower Complement C4 Gene Copy Number Is A Genetic Risk Factor For Type 1 Diabetes Mellitus In Pediatric Patients. Pediatric Research, vol. 66, no. 4, pp. 472-472. 2009.

3. **Kingery SE** and Nicholson Y. Diagnostic challenges in children with parathyroid adenomas: a case report. Lawson Wilkins Pediatric Endocrine Society/ European Pediatric Endocrine Society Joint Meeting, New York NY, September 2009. Hormone Research, vol. 72, pp. 226-226. 2009.

4. **Kingery SE,** Wu YL, Hoffman RP, Yu CY. Higher Complement C4 Protein Levels Are Positively Correlated with β-Cell Preservation in New Onset Type 1 Diabetes Mellitus. Endocrine Society Annual Meeting. San Diego CA, June 2010. *Endocrine Reviews*. 2010; 31 (Suppl 1)

5. **Kingery SE**, Wu YL, Zhou B, Hoffman RP, Yu CY. Complement C4 as Novel Biomarkers for Partial Disease Remissions in New Onset Type 1 Diabetes Patients. American Diabetes Association Annual Scientific Meeting, San Diego CA, June 2011. *Diabetes*. 2011; 60 (Supp1)

6. Omoruyi AO, Foster MB, **Kingery SE**, Wintergerst KA. A Case Report of Neonatal Diabetes Mellitus in Schinzel-Giedion Syndrome. Endocrine Society Annual Meeting. Houston TX, June 2012.

7. Kuhl EA, Foster MB, Omoruyi AO, **Kingery SE**, Wintergerst KA. The Impact of Insurance Coverage and the Family on Pediatric Diabetes Management: A 4 Year Experience. Diabetes Technology and Therapeutics Meeting, Bethesda MD, Nov 2012.

8. Omoruyi AO, Foster MB, **Kingery SE**, Wintergerst KA. A Case of Mayer-Rokitansky-Hauser Syndrome in a 6 Year-Old Female With Precocious Puberty. Academic Pediatric Society-Society for Pediatric Research Meeting, Vancouver, Canada, May 2014.

9. Omoruyi AO, Foster MB**, Kingery SE**, Wintergerst KA. A Case of Mayer-Rokitansky-Hauser Syndrome in a 6 Year-Old Female With Precocious Puberty. Endocrine Society Annual Meeting, Chicago, IL, June 2014

10. **Kingery SE**, Spurling S, Foster MB, Omoruyi AO, Watson SE, and Wintergerst KA. Multi-disciplinary team approach improves glycemic control and health behaviors in high risk youth with type 1 diabetes mellitus. Endocrine Society Annual Meeting. Boston MA, April 2016. Endocrine Reviews. 2016; 37(2)

11. Neff A, **Kingery SE**. Evaluation of first year medical students' knowledge and attitudes regarding differences in sexual development using a problem-based learning case on complete androgen insensitivity syndrome. GLMA Annual Conference. St Louis, MO, September 2016.

12. Neff A, Steinbock S, Sawning S, **Kingery SE**. Teaching 1st Year Medical Students about Complete Androgen Insensitivity Syndrome: Curriculum methods to teach about Differences in Sex Development (DSD). Southern Group on Educational Affairs (SGEA) Conference. Charlottesville, VA, April 2017.

13. Neff A, Steinbock S, Sawning S, **Kingery SE.** Teaching 1st Year Medical Students about Complete Androgen Insensitivity Syndrome: Curriculum methods to teach about Differences in Sex Development (DSD). Pediatric Endocrine Society Annual Meeting. Washington DC, September 2017.

14. Peterson E, **Kingery SE**, Watson S. Pediatric Mixed Diabetic Ketoacidosis and Hyperglycemic Hyperosmolar Syndrome. Pediatric Critical Care Summit of the Americas. Houston, TX, November 2019.

15. Bohnert C, Brady C, Bush B, Cash E, Combs R, Compton D, Decker H, Holthouser A, Jones VF, **Kingery SE**, Latta G, Martin L, Neff A, Noonan EJ, Sawning S, Shaw MA, Stephens J, Weathers A, Weingartner LA. eQuality: Resources from Five Years of an Integrated LGBTQ Health Curriculum Initiative. AAMC National Meeting. Virtual. November 2020.

16. **Kingery SE**, Folsom LJ. Quality of Life and Psychological Comorbidities in Youth on Gender Affirming Hormone Therapy. Pediatric Endocrine Society Annual Meeting. Virtual. May 2021.

17. Komeswaran K, Watson S, **Kingery SE**, Peterson E. A case series: Mixed Presentations of Hyperglycemic Hyperosmolar Syndrome and Diabetic Ketoacidosis. Society of Critical Care Medicine. San Juan, Puerto Rico. February 2022.

PUBLICATIONS

Articles Published in Peer-Reviewed Journals

1. Rutherford A, Zhou B, Wu YL, **Kingery SE**, Germak J, Bowden S, Yu CY. Analysis of the human amylase locus revealed extensive copy number variation of salivary and pancreatic amylase genes in type 1 diabetes patients. Pediatric Research. 2011, 70 (4): 429.

2. **Kingery SE**, Wu YL, Zhou B, Hoffman RP, Yu CY. Gene CNVs and protein levels of complement C4A and C4B as novel biomarkers for partial disease remissions in new-onset type 1 diabetes patients. Pediatric Diabetes. 2012; 13 (5): 408-418. doi: 10.1111/j.1399-5448.2011.00836.x. PMID: 22151770

3. Akintola KO, Omoruyi AO, Foster MD, **Kingery SE,** Wintergerst. Behavioral Disorders associated with GnRH agonist therapy. Experimental and Clinical Endocrinology & Diabetes Reports. 2014 *2*(01), e1-e3.

4. Farrell R, Foster MB, Omoruyi A, **Kingery SE**, Wintergerst KA. Hashimoto's Encephalopathy: A rare cause of neurologic disease in children. J Pediatr Endocrinol Metab. 2015; 28(5-6):721-4. doi: 10.1515/jpem-2014-0205. PMID: 25581742

5. **Kingery SE**, Wintergerst KA. Turner Syndrome and Klinefelter Syndrome. Adolescent Medicine: State of the Art Reviews. 2015; 26(2): 411-427. PMID: 26999880

6. Myers, WT, Wintergerst KA, **Kingery SE,** Foster, MB**.** Generalized anasarca in 15 year old girl with Type 1 diabetes mellitus. Pediatrics in Review. 2016; 37(2):81. doi: 10.1542/pir.2015-0088. PMID: 26834228.

7. Watson S, Kuhl E, Foster MB, Omoruyi A, **Kingery SE**, Woods C, Wintergerst KA. The Impact of Insurance Coverage and the Family on Pediatric Diabetes Management. Pediatric Diabetes. 2016 May 10. doi: 10.1111/pedi.12394. PMID: 27161659.

8. Neff A, **Kingery SE.** Complete androgen insensitivity syndrome: a problem-based learning case. MedEdPORTAL Publications. 2016;12:10522. https://doi.org/10.15766/mep_2374-8265.10522ortal. PMID: 30984864

9. Wintergerst, KA, **Kingery SE**, Gembel G, Kriepe T, Zeller P, Eugster E, Young W, Andruszewski K, Kleyn M, Cunningham T, Fawbush S, Vanderburg N, Sockalosky J, Menon R, Linard S, Hoffman G, Gorman L. Congenital Hypothyroidism (CH) 3-Year Follow-Up Project: Results from the Region 4 Midwest Genetics Collaborative. Int. J. Neonatal Screen. 2018, 4, 18; doi:10.3390/ijns4020018

10. Logan L, **Kingery SE.** Breast Development in a 2 Year Old Girl. Pediatrics in Review. 2018; 39(12):612-613. doi: 10.1542/pir.2017-0133. PMID: 30504253

11. Weingartner LA, Noonan EJ, Holthouser A, Potter J, Steinbock S, **Kingery SE**, Sawning S. The eQuality Toolkit: Practical Skills for LGBTQ and DSD-Affected Patient Care. Lexington, KY: University Press of Kentucky; 2019. doi: 10.18297/faculty/391

12. DiMeglio LA , Kanapka LG, Woerner S, Laffel LM, **Kingery SE**, et al. A randomized clinical trial assessing continuous glucose monitoring (CGM) use with standardized education with or without a family behavioral intervention compared with fingerstick blood glucose monitoring in very young children with type 1 diabetes. Diabetes Care 2021; 44(2):464-472. PMID: 33334807 DOI: 10.2337/dc20-1060

13. CichoskiKelly, E, **Kingery, SE**, Sawning, S, Stepleman, L. Incorporating Sexual and Gender Minority Patient Care Competencies: A Case Based Curriculum Caring for Gender Diverse Youth. (In-progress)

Continuing Medical Education and Professional Development Courses Published:

1. Weingartner LA, Noonan EJ, Holthouser A, Potter J, Steinbock S, **Kingery SE**, Sawning S. Evidence-Based Care of LGBTQ-DSD Patients Using The eQuality Toolkit. 3.0 AMA PRA Category 1 Credits. Course Originally Released on August 2019. *http://louisville.edu/medicine/cme/credits/eQuality19*

Articles Published in Non Peer-Reviewed Journals:

1. **Kingery SE**, Wintergerst KA. Clinical Practice Guidelines on the Management of Newly Diagnosed Type 2 Diabetes Mellitus in Children and Adolescents. Kentucky Diabetes Connection. 2013 March.

2. **Kingery SE**. Childhood obesity—A medical concern. Posted in Children, Family, Wellness on uoflphysicians.com/blog on April 19, 2016. http://www.uoflphysicians.com/blog/2016/04/19/childhood-obesity-a-medical-concern/

Audio Publications:

1. **Kingery SE.** Presenter. "Addressing the LGBTQ Pediatric Patient." MedChat. 2021 May. https://medchat.libsyn.com/addressing-the-lgbtq-pediatric-patient

Video Publications:

1. **Kingery, SE.** Presenter. "Engage on Inclusive Health Care for the LGBTQ+ Community." Engage. 2021 October.

Exhibit B

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Achille, C., Taggart T., Eaton N., Osipoff J., Tafuri K., Lane A., Wilson T. (2020). Longitudinal Impact of Gender-Affirming Endocrine Intervention on the Mental Heath and Well-Being of Transgender Youths: Preliminary Results. *International Journal of Pediatric Endocrinology*. 2020:8. doi.org/10.1186/s13633-020-00078-2

De Vries ALC, Steensma TD, Doreleijers TAH, and Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *J Sex Med.* 2011;8:2276–2283.

Rafferty J. (2018). 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. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. *Pediatrics*. 142(4):e20182162.

Tordoff D., Wanta J., Collin A, Stephney C, Inwards-Breland D, Ahrens K. (2022). Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Network Open* 2022;5(2):e220978. doi:10.1001/jamanetworkopen.2022.0978

Turban JL, King D, Kobe J, Reisner SL, Keuroghlian AS (2022) Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS ONE* 17(1): e0261039.

Turban JL, King D, Carswell JM, et al. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*. 2020;145(2):e20191725.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY

JANE DOE 1, *et al.*, *Plaintiffs,* v. WILLIAM C. THORNBURY, JR., MD, in his official capacity as the President of the Kentucky Board of Medical Licensure, *et al.*, *Defendants.*	Case No. 3:23-cv-00230-DJH

DECLARATION OF JANE DOE 1 IN SUPPORT OF
PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Jane Doe 1,[1] hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify. I have personal knowledge of the information contained in this Declaration and would testify completely to those facts if called to do so.

2. I am a plaintiff in this Action, and I am the parent and next friend of my minor child, John Minor ("JM") Doe 1, who is also a Plaintiff in this action.

3. I am a Kentucky resident. I live in Jefferson County with my husband and three children.

[1] Because of concerns about my child's privacy and safety, I have moved to proceed in this case under a pseudonym. *See Pls.' Mot. for Leave to Proc. Pseudonymously,* ECF No. 1. I have contemporaneously signed with my legal name a separate copy of this declaration. My attorneys have a copy of that separate declaration.

4. My son, JM Doe 1, who is also a Plaintiff in this action, is a twelve-year-old transgender boy.

5. When JM Doe 1 "came out" as transgender when he was about eleven, I was not surprised. He had come out to my husband and me as nonbinary a few years previous, and as a lesbian before that. When he was a little boy, he asked, "Mom, did you always know you were a girl?"

6. When JM Doe 1 began puberty and started menstruating in December 2021, his mental health declined dramatically. He became suicidal during and around his periods. In Spring 2022, after his second period, my husband and I hospitalized JM Doe 1 because he told a classmate that he wanted to die.

7. That fall, JM Doe 1 was diagnosed with gender dysphoria. His diagnosis was the result of numerous hours of interviews with therapists, psychiatrists, a pediatric nurse practitioner, and an endocrinologist.

8. Managing JM Doe 1's depression and suicidality has always been my main priority. My husband and I worked closely with JM Doe 1's doctors to come up with a treatment plan. In November 2022, JM Doe 1 began taking puberty blockers to stop his periods. My husband and I saw an immediate improvement in his emotional and mental health. It did not take long for JM Doe 1 to return to the happy child he used to be before his first period. Taking puberty blockers has dramatically reduced JM Doe 1's suicidality. JM Doe 1 continues to receive hormone treatment in Kentucky.

9. My husband and I are very concerned about what might happen to JM Doe 1 if the Treatment Ban prevents him from being treated with puberty blockers in Kentucky. My son and husband have described this treatment as a "lifesaving and life changing experience." I do not

know whether our family will be able to obtain this treatment out-of-state. We worry that JM Doe 1's symptoms of distress will return without continued treatment.

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

Executed this 22nd day of May 2023.

/s/ Jane Doe 1
Jane Doe 1

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY

JANE DOE 1, *et al.*, *Plaintiffs*, v. WILLIAM C. THORNBURY, JR., MD, in his official capacity as the President of the Kentucky Board of Medical Licensure, *et al.*, *Defendants*.	Civil No.: 3:23-CV-00230-DJH

DECLARATION OF JOHN DOE 2 IN SUPPORT OF
PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, John Doe 2,[1] hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify. I have personal knowledge of the information contained in this Declaration and would testify completely to those facts if called to do so.

2. I am a plaintiff in this Action and I am the parent and next friend of my minor child, John Minor ("JM") Doe 2, who is also a Plaintiff in this action.

3. I currently reside in the Eastern District of Kentucky with my sister and son.

4. My son, JM Doe 2, is a fifteen-year-old transgender boy.

[1] Because of concerns about my child's privacy and safety, I have moved to proceed in this case under a pseudonym. *See Pls.' Mot. for Leave to Proc. Pseudonymously,* ECF No. 1. I have contemporaneously signed with my legal name a separate copy of this declaration. My attorneys have a copy of that separate declaration.

5. When JM Doe 2 was in the first grade he would occasionally ask to be called by a male name and male pronouns. He has always preferred "boy's" clothes, and, from a young age, periodically questioned whether something was "wrong" with him.

6. JM Doe 2 "came out" as a boy at home and at school in about the seventh or eighth grade. As part of his coming out process, JM Doe 2 cut his hair and began using male pronouns. He recently even obtained a legal name change. When JM Doe 2 began puberty and started menstruating, he felt depressed and distressed by the mismatch between his body and gender identity.

7. I have seen numerous healthcare professionals with JM Doe 2. After many evaluations and careful discussions regarding the risks and benefits of treatment, JM Doe 2 began receiving gender-affirming medications. He first began using birth control pills to stop his periods. He then began testosterone treatment. He continues to receive this care in Kentucky. He also sees a therapist.

8. Hormone therapy has significantly improved JM Doe 2's mood and sense of self. For instance, JM Doe 2 feels tremendous pride when he sees his body changing to match his male identity. I have never seen JM Doe 2 as happy as he is now that he is receiving the treatment. JM Doe 2 has not experienced any negative impact by the use of the hormone therapy.

9. I believe that if the Treatment Ban prevents JM Doe 2 from continuing with his treatment – the birth control and testosterone – that JM Doe 2 would revert to his previous mental state. JM Doe 2 has told me that he cannot imagine his life without this medical treatment. I do not know whether my family will be able to obtain this treatment out-of-state.

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

Executed this 22nd day of May 2023.

/s/ John Doe 2
John Doe 2

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY

JANE DOE 1, *et al.*, *Plaintiffs,* v. WILLIAM C. THORNBURY, JR., MD, in his official capacity as the President of the Kentucky Board of Medical Licensure, *et al.*, *Defendants.*	Civil No. 3:23-cv-00230-DJH

DECLARATION OF JOHN DOE 3 IN SUPPORT OF
PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, John Doe 3,[1] hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify. I have personal knowledge of the information contained in this Declaration and would testify completely to those facts if called to do so.

2. I am a Plaintiff in this Action, as well as the parent and next friend of my minor child, Jane Minor ("JM") Doe 3, who is also a Plaintiff in this action.

3. I am a Kentucky resident. I live in Jefferson County, Kentucky with my daughter, JM Doe 3, and my wife.

4. My daughter, JM Doe 3, who is also a Plaintiff in this action, is an eleven-year-old transgender girl.

[1] Because of concerns about my child's privacy and safety, I have moved to proceed in this case under a pseudonym. *See Pls.' Mot. for Leave to Proc. Pseudonymously,* ECF No. 1. I have contemporaneously signed with my legal name a separate copy of this declaration. My attorneys have a copy of that separate declaration.

5. JM Doe 3 has known since a very young age that she is a girl. She started asking for "girl's" clothes when she was six; she grew out her hair when she was eight and stopped using her birth name when she was nine.

6. JM Doe 3 told my wife and me that she is a girl in March 2022, when she was nine. Because of the stigma associated with transgender identity, we feared for her safety.

7. At the start of fifth grade, shortly after "coming out" to me, JM Doe 3 socially transitioned. Although some of our fears came true, and JM Doe 3 faces some bullying at school and has been rejected by several family members, she has mostly been accepted by peers and family.

8. My wife and I identified a psychologist for JM Doe 3 after extensive research and consultations. JM Doe 3 now receives mental health care for gender dysphoria and generalized anxiety disorder.

9. JM Doe 3's psychologist diagnosed her with gender dysphoria in Spring of 2022. We were then referred to a pediatric endocrinologist.

10. Our initial appointment with the pediatric endocrinologist lasted more than two hours and included a thorough evaluation of JM Doe 3's mental and physical health, as well as a detailed explanation of the different options available to her.

11. In January 2023, after considering the various treatment options, my wife and I consented to have a pediatric surgeon implant a device in JM Doe 3's arm to administer puberty blockers. The surgeon explained the risks associated with the treatment and examined JM Doe 3's motivations for and comprehension of the procedure. My wife and I were and remain comforted by the knowledge that JM Doe 3's treatment is not only supported by all major US medical associations, but is also reversible.

12. JM Doe 3 continues to receive treatment in Kentucky. An endocrinologist frequently monitors JM Doe 3's implant. JM Doe 3's next appointment with her endocrinologist is in June 2023.

13. JM Doe 3's endocrinologist has informed us that she will no longer be able to treat JM Doe 3 once the Treatment Ban goes into effect on June 29 and will instead have to refer us out-of-state. My wife and I are unsure whether we will be able to obtain out-of-state care for JM Doe 3.

14. Puberty blockers have made JM Doe 3's gender dysphoria and anxiety symptoms more manageable. My wife and I are fearful of the physical, emotional, and psychological consequences of discontinuing them. We worry that JM Doe 3's symptoms of distress will return without continued treatment.

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

Executed this 22nd day of May 2023.

/s/ John Doe 3
John Doe 3

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY

JANE DOE 1, *et al.*, *Plaintiffs*, v. WILLIAM C. THORNBURY, JR., MD, in his official capacity as the President of the Kentucky Board of Medical Licensure, *et al.*, *Defendants*.	Civil No.: 3:23-CV-00230-DJH

DECLARATION OF JANE DOE 5 IN SUPPORT OF
PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Jane Doe 5,[1] herby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify. I have personal knowledge of the information contained in this Declaration and would testify completely to those facts if called to do so.

2. I am a plaintiff in this Action and I am the parent and next friend of my minor child, John Minor ("JM") Doe 5, who is also a Plaintiff in this action.

3. I am a Kentucky resident. I live in the Eastern District of Kentucky with my two children and my husband John Doe 5.

4. My son, JM Doe 5, who is also a Plaintiff in this action, is a sixteen-year-old transgender boy.

[1] Because of concerns about my child's privacy and safety, I have moved to proceed in this case under a pseudonym. *See Pls.' Mot. for Leave to Proc. Pseudonymously,* ECF No. 1. I have contemporaneously signed with my legal name a separate copy of this declaration. My attorneys have a copy of that separate declaration.

5. JM Doe 5 was born in the state of Kentucky and has told me that he considers himself a native Kentuckian. He has a deep love for Kentucky and has consistently told us that he plans to make a life for himself in Kentucky.

6. JM Doe 5 has known since a young age that he was not a girl. At eleven, he started to wear his hair short and dress more androgynously. He expressed discomfort when I encouraged him to wear earrings or look more feminine.

7. JM Doe 5 began using a male name and male pronouns in seventh grade. He "came out" to me as transgender the summer after eighth grade. Because of the stigma associated with transgender identity, I feared for his safety.

8. When JM Doe 5 began puberty and started menstruating, he experienced extreme distress. My husband and I took him to a gynecologist to discuss possible treatment options. The gynecologist prescribed birth control pills to stop JM Doe 5's periods.

9. After providing detailed information regarding treatment options and associated risks, a physician recommended that JM Doe 5 take testosterone. My husband and I considered the risks of this treatment at length. We consented to the treatment and JM Doe 5 began taking testosterone in January 2023. He continues to receive this care within the State. JM Doe 5 also sees a therapist.

10. We almost immediately noticed a positive change in JM Doe 5's mental health after he started testosterone. JM Doe 5 is happier, more confident, and more outgoing. He appears more comfortable in public and more at home in his body.

11. My husband and I are very concerned about what might happen to JM Doe 5 if the Treatment Ban prevents him from continuing his testosterone treatment in Kentucky. Our family will be forced to either seek treatment for JM Doe 5 in another state or discontinue the treatment

that has made such a profoundly positive change in his life. We do not know whether we will be able to obtain this treatment out-of-state while remaining in Kentucky. JM Doe 5 may be forced to move away from the home state that he holds dear. We worry that JM Doe 5's symptoms of distress will return without continued treatment.

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

Executed this 22nd day of May 2023.

/s/ Jane Doe 5
Jane Doe 5

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY

JANE DOE 1, *et al.*, *Plaintiffs,* v. WILLIAM C. THORNBURY, JR., MD, in his official capacity as the President of the Kentucky Board of Medical Licensure, *et al.*, *Defendants.*	Civil No. 3:23-cv-00230-DJH

[PROPOSED] PRELIMINARY INJUNCTION

This matter having come before the Court upon the Motion for Preliminary Injunction filed by John and Jane Minor Does 1-3 and 5, and their parents, John and Jane Does 1-3 and 5, (collectively "Plaintiffs"); for good cause shown, it is hereby ORDERED that Plaintiffs' Motion for Preliminary Injunction is GRANTED.

On March 16, 2023, the Kentucky Legislature passed Senate Bill 150 ("SB 150"). Sections 4(2)(a) and (b) of SB 150 (the "Treatment Ban") are scheduled to take effect on June 29, 2023. These sections make it unlawful for a healthcare provider to administer any medicine, including puberty blockers and hormones, "for the purpose of attempting . . . to validate a minor's" gender identity. Plaintiffs seek to enjoin enforcement of the Treatment Ban until this Court issues a final judgment on the merits of their claims for relief.

The Court, having considered the pleadings, legal authority, and argument presented in support of Plaintiffs' Motion, as well as the sworn declarations submitted in support of that Motion, has found and concluded for the specific reasons required under Federal Rule of Civil Procedure 65(d) that Plaintiffs have demonstrated: (1) a likelihood of success on the merits, that they will

suffer irreparable harm if a preliminary injunction is not granted, (3) that the balance of equities tip in Plaintiffs' favor, and (4) that a preliminary injunction is in the public interest.

Plaintiffs have established a likelihood of success on the merits of their claim that the Treatment Ban violates the Due Process Clause of the Fourteenth Amendment by interfering with the Parent Plaintiffs' exercise of their fundamental rights to seek and determine medical care for their children. Plaintiffs have also established a likelihood of success on the merits of their claim that the Treatment Ban violates Plaintiffs' right to equal protection under the Fourteenth Amendment to the U.S. Constitution by making it unlawful to provide medically necessary care to transgender youth.

Plaintiffs have demonstrated that, absent injunctive relief preventing the Treatment Ban from taking effect, they will be denied medical care and suffer irreparable constitutional, physical, emotional, psychological, and other harms for which there is no adequate remedy at law. The balance of hardships between the injuries Plaintiffs will suffer and Defendants' interests weigh in favor of granting Plaintiffs' motion to preserve the status quo, and an injunction is in the public interest.

The Court finds that Plaintiffs are not required to provide security pursuant to Fed. R. Civ. P. 65(c).

IT IS THEREFORE ORDERED that Defendants, as well as their agents, employees, servants, attorneys, successors and any person in active concert or participation with them, are HEREBY ENJOINED, pending final judgment, from enforcing, threatening to enforce, or otherwise requiring compliance with the Treatment Ban.

IT IS FURTHER ORDERED that the security requirement of Fed. R. Civ. P. 65(c) is waived and that this injunctive relief is effective upon service.

Executed this ___ day of ___, 2023.

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