

**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

**REPLY IN SUPPORT OF PLAINTIFFS'
MOTION FOR A PRELIMINARY INJUNCTION**

TABLE OF CONTENTS

	Page
INTRODUCTION	1
ARGUMENT	1
I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS.	1
A. Precedent Forecloses Cameron’s Arguments Against Heightened Scrutiny.	1
B. Cameron Cannot Avoid Strict Scrutiny On Plaintiffs’ Due Process Claim.	6
C. Cameron’s Proffered Justifications Do Not Withstand Scrutiny.	8
1. Gender dysphoria is a recognized medical condition.	8
2. Adolescents with gender dysphoria overwhelmingly do not “desist.”	9
3. Treatments for gender dysphoria are safe and effective.	9
4. The international medical consensus supports the use of puberty blockers and hormone therapy for transgender adolescents.	10
5. Anecdotes do not justify banning established medical care for a serious medical condition.	10
6. Robust evidence shows the safety and efficacy of medical treatments for gender dysphoria in adolescents.	11
7. WPATH and the Endocrine Society guidelines are based on evidence.	12
8. There is no evidence that psychotherapy alone is effective.	13
9. Minors can provide informed assent to treatment.	13
II. A PRELIMINARY INJUNCTION AGAINST ALL ENFORCEMENT OF THE TREATMENT BAN IS NECESSARY TO PROTECT PLAINTIFFS.	14
CONCLUSION	15

TABLE OF AUTHORITIES

Cases	Page(s)
<i>Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach</i> , 495 F.3d 695 (D.C. Cir. 2007).....	8
<i>Bassett v. Snyder</i> , 951 F. Supp. 2d 939 (E.D. Mich. 2013).....	16
<i>Blakley v. Comm’r of Soc. Sec.</i> , 581 F.3d 399 (6th Cir. 2009)	16
<i>Bonnell v. Lorenzo</i> , 241 F.3d 800 (6th Cir. 2001)	16
<i>Bostock v. Clayton Cnty.</i> , 140 S. Ct. 1731 (2020).....	3, 4
<i>Brandt v. Rutledge</i> , 47 F.4th 661 (8th Cir. 2022)	<i>passim</i>
<i>Craig v. Boren</i> , 429 U.S. 190 (1976).....	6
<i>Dobbs v. Jackson Women’s Health Org.</i> , 142 S. Ct. 2228 (2022).....	5, 6
<i>Doe v. Ladapo</i> , 2023 WL 3833848 (N.D. Fla. 2023).....	<i>passim</i>
<i>Edmo v. Idaho Dep’t of Corr.</i> , 358 F. Supp. 3d 1103, <i>vacated in part on other grounds</i> , 935 F.3d 757 (9th Cir. 2019)	14
<i>Eknes-Tucker v. Marshall</i> , 603 F. Supp. 3d 1131 (M.D. Ala. 2022)	<i>passim</i>
<i>Geduldig v. Aiello</i> , 417 U.S. 484 (1974).....	5, 6
<i>Grimm v. Gloucester Cnty. Sch. Bd.</i> , 972 F.3d 586 (4th Cir. 2020)	3
<i>K.C. v. Medical Licensing Bd.</i> , No. 1:23-cv-00595, ECF No. 67, slip op. 32–33 (S.D. Ind. June 16, 2023)	1, 6, 10
<i>Kanuszewski v. Mich. Dep’t of Health & Human Servs.</i> , 927 F.3d 396 (6th Cir. 2019)	7

TABLE OF AUTHORITIES

Cases	Page(s)
<i>Karnoski v. Trump</i> , 926 F.3d 1180 (9th Cir. 2019)	5, 6
<i>Loving v. Virginia</i> , 388 U.S. 1 (1967).....	5
<i>Mulholland v. Marion Cnty. Elec. Bd.</i> , 746 F.3d 811 (7th Cir. 2014)	17
<i>Nguyen v. INS</i> , 533 U.S. 53 (2001).....	2
<i>Norsworthy v. Beard</i> , 87 F. Supp. 3d 1164 (N.D. Cal. 2015)	14
<i>Obergefell v. Hodges</i> , 576 U.S. 644 (2015).....	5
<i>Phillips v. Martin Marietta Corp.</i> , 400 U.S. 542 (1971).....	5
<i>Pickup v. Brown</i> , 740 F.3d 1208 (9th Cir. 2014)	8
<i>Pierce v. Soc’y of Sisters</i> , 268 U.S. 510 (1925).....	8
<i>C.P. ex rel. Pritchard v. Blue Cross Blue Shield</i> , 2022 WL 17092846 (W.D. Wash. 2022).....	14
<i>Roman Catholic Diocese v. Cuomo</i> , 141 S. Ct. 63 (2020).....	9
<i>San Antonio Indep. Dist. v. Rodriguez</i> , 411 U.S. 1 (1973).....	8
<i>Smith v. City of Salem</i> , 378 F.3d 566 (6th Cir. 2004)	1, 2, 3, 4
<i>United States v. Virginia</i> , 518 U.S. 515 (1996).....	2
<i>Vacco v. Quill</i> , 521 U.S. 793 (1997).....	6

TABLE OF AUTHORITIES

Cases

Page(s)

Washington v. Reno,
35 F.3d 1093 (6th Cir. 1994)17

INTRODUCTION

The Department of Justice (ECF No. 37) and more than twenty major medical organizations, including those with expertise in the treatment of gender dysphoria (ECF No. 19), agree that the Treatment Ban contradicts sound medical science and will cause Plaintiffs irreparable harm. Every court to consider challenges to similar bans has agreed that a preliminary injunction is warranted. *See Brandt v. Rutledge*, 47 F.4th 661, 667 (8th Cir. 2022); *K.C. v. Medical Licensing Bd.*, No. 1:23-cv-00595, ECF No. 67, slip op. 32–33 (S.D. Ind. June 16, 2023) (attached as Exhibit 1); *Doe v. Ladapo*, 2023 WL 3833848, at *1 (N.D. Fla. 2023); *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1146 (M.D. Ala. 2022). Defendants Thornbury and Denker, officials responsible for enforcing the Treatment Ban, agree it would “behoove ... licensees and their patients for the Court to grant the injunction and maintain the status quo pending final ruling on the merits of the suit, to avoid potentially unnecessary cost, time, and harmful exposure should Plaintiffs be successful.” ECF Nos. 41 at 1-2. Against that backdrop, an order enjoining Defendants from enforcing the Treatment Ban for the duration of this case is warranted. Attorney General Cameron fails to show otherwise.

ARGUMENT

I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS.

A. Precedent Forecloses Cameron’s Arguments Against Heightened Scrutiny.

Cameron misconstrues Supreme Court and Sixth Circuit precedent, which establishes that discrimination based on transgender status is prohibited sex discrimination. The Sixth Circuit has held that discrimination against transgender persons is sex-based discrimination for purposes of the Equal Protection Clause. *Smith v. City of Salem*, 378 F.3d 566, 577 (6th Cir. 2004). This is so because discrimination against transgender persons is discrimination against a person for failing “to act and/or identify with his or her gender.” *Id.* at 575. The Treatment Ban targets transgender

youth. Thus, under *Smith*, the Ban is presumptively invalid and cannot be upheld without an “exceedingly persuasive justification.” *United States v. Virginia*, 518 U.S. 515, 531 (1996). Here, as every court to consider similar bans on medical treatments for transgender youth has concluded, the government’s asserted justifications fall far short of this demanding test. *See Brandt*, 47 F.4th at 670–71; *Eknes-Tucker*, 603 F. Supp. 3d at 1147–48; *Ladapo*, 2023 WL 3833848, at *10–11.

Cameron attempts to avoid *Smith* by arguing that the Treatment Ban does not discriminate based on sex because it draws classifications based on “inherent physical differences” between boys and girls, not sex stereotypes. ECF No. 45 (“Opp.”) at 11. Heightened scrutiny applies to *all* sex-based classifications. Cameron’s argument to the contrary fails for two reasons. *First*, it conflates two distinct questions: (a) whether a sex-based classification exists, and (b) whether the sex-based classification survives scrutiny. Whether a classification arises from “physical differences” relates only to this second question.¹ Indeed, both of the cases Cameron cites in an attempt to escape heightened scrutiny *apply heightened scrutiny*. *See Nguyen v. INS*, 533 U.S. 53, 60–61, 70 (2001); *Virginia*, 518 U.S. at 556. No authority holds that a sex-based classification avoids strict scrutiny simply because it relates to “inherent physical differences.”

The Treatment Ban explicitly references “sex” to define the treatments it prohibits. The statute prohibits treatments that “alter the appearance” or “validate a minor’s perception of[] the minor’s sex, if that appearance or perception is inconsistent with minor’s sex” at birth. SB 150 § 4(2). The prohibition “cannot be stated without referencing sex,” and “[o]n that ground alone, heightened scrutiny should apply.” *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 608 (4th Cir. 2020) (cleaned up); *accord Brandt*, 47 F.4th at 669. “If one must know the sex of a person to know whether or how a provision applies to the person, the provision draws a line based on sex.”

¹ Further, physical differences do not independently constitute an “exceedingly persuasive” justification. *Virginia*, 518 U.S. at 533.

Ladapo, 2023 WL 3833848, at *8; accord *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1741–42 (2020) (holding that “sex plays an unmistakable and impermissible role” in discrimination against transgender individuals).

Second, the Treatment Ban expressly relies on sex stereotypes. It only prohibits hormones and puberty blockers for the purpose of affirming a gender identity that “is inconsistent with” with a minor’s natal sex, (SB 150 § 4(2)); *see also* ECF No. 17-3 (“Kingery Decl.”) at ¶ 35—that is, it only prohibits these medicines for minors who fail to “act and/or identify with his or her gender,” *Smith*, 378 F.3d at 575. By only banning gender-affirming treatments, the Treatment Ban mandates that a minor have an appearance and identity that is consistent with the appearance and identity stereotypically associated with his or her natal sex. As the Sixth Circuit has made clear: “discrimination against a plaintiff who is a trans[] . . . is no different from the discrimination directed against [a woman], who, in sex-stereotypical terms, did not act like a woman.” *Id.* at 576. Mandating gender conformity is sex discrimination.

Cameron also claims that the Treatment Ban does not discriminate based on sex because it applies equally to boys and girls. *Opp.* at 9. In *Bostock*, the Supreme Court considered and rejected this same argument: “[A]n employer who intentionally fires an individual . . . transgender employee . . . violates the law *even if* the employer is willing to subject all male and female . . . transgender employees to the same rule.” *Bostock*, 140 S. Ct. at 1744 (emphasis added). So, too, here.

Cameron next argues that *Bostock*’s explanation of sex discrimination is limited to Title VII and does not apply to an equal protection claim. *Opp.* at 10. Sixth Circuit precedent forecloses his argument. Courts have made clear that a plaintiff alleging a violation of the Equal Protection Clause “must prove the same elements as are required to establish a disparate treatment claim

under Title VII.” *Smith*, 378 F.3d at 577 (cleaned up). Cameron’s reliance on *Pelcha* is misplaced. *Opp.* at 10. Unlike *Smith*, *Pelcha* does not analyze the relationship between sex discrimination claims under Title VII and the Equal Protection Clause. *Pelcha* only considers whether an *age discrimination* claim under the Age Discrimination in Employment Act should be analyzed under the same test as a sex discrimination claim under Title VII. *Pelcha*, 988 F.3d at 324.

Moreover, contrary to Cameron’s view, it is irrelevant that some transgender youth do not receive the banned treatments. *See Opp.* at 9, 11. A law need not apply to *all* members of a group to draw impermissible distinctions based on sex. For example, in *Phillips v. Martin Marietta Corp.*, 400 U.S. 542, 543–44 (1971), the Court held that a workplace policy that applied only to women with children discriminated based on sex, even though not all women have children. Similarly, the Court has held laws that ban interracial and same-sex couples from marriage discriminate based on race and on sexual orientation, respectively, even though not all such couples wish to marry. *See Obergefell v. Hodges*, 576 U.S. 644, 675 (2015); *Loving v. Virginia*, 388 U.S. 1, 12 (1967).

Cameron’s argument that the Treatment Ban targets procedures rather than transgender people is equally unavailing. *See Opp.* at 12. Because the law targets treatments only for treatment purposes transgender people require, it discriminates based on transgender status. *See, e.g., Karnoski v. Trump*, 926 F.3d 1180, 1201 (9th Cir. 2019) (policy banning individuals who have undergone “gender transition” from open military service discriminates based on transgender status). On its face, the Treatment Ban prohibits treatments only for a minor whose “perception of his or her sex ... is inconsistent with the minor’s sex” at birth—*i.e.*, only for and to treat transgender minors. There is no mystery or ambiguity about the class of minors for whom the Treatment Ban’s “protections” were enacted.

Cameron’s reliance on *Geduldig v. Aiello*, 417 U.S. 484 (1974), and *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228 (2022), is misplaced. Those cases involved policies that did not facially discriminate based on sex: nobody received health coverage for pregnancy (*Geduldig*); nobody had the right to an abortion (*Dobbs*). In contrast, the Treatment Ban makes a facial distinction between transgender and cisgender youth. *See Ladapo*, 2023 WL 3833848, at *3 (rejecting the argument that a substantially identical treatment ban for Florida transgender adolescents survived under *Geduldig*). Neither *Geduldig*, *Dobbs*, nor any other case, holds that facial sex-based classifications can avoid heightened scrutiny simply because they relate to the regulation of medical care. *See Ladapo*, 2023 WL 3833848, at *3; *K.C.*, slip op. 18.

Cameron’s argument that the Treatment Ban targets “medical-procedures-*for-a-specific-purpose*,” Opp. at 12 (emphasis added), proves Plaintiffs’ point. That specific purpose is to prevent gender transition by transgender persons. *See, e.g., Karnoski*, 926 F.3d at 1201. Cameron’s reliance on *Vacco v. Quill*, 521 U.S. 793 (1997), which involved a law prohibiting euthanasia, is profoundly misplaced for this reason. *See Opp.* 12. Prohibiting euthanasia does not single out any particular group, much less based on sex.

It is irrelevant that the Treatment Ban also draws a classification based on age. *See Opp.* at 12. Laws can create multiple distinctions based on multiple classes. An appropriate distinction does not cure a distinction that the Equal Protection Clause forbids. *See, e.g., Craig v. Boren*, 429 U.S. 190, 192 (1976) (analyzing a law prohibiting the sale of 3.2% beer to males under the age of 21 and to females under the age of 18 as a “gender-based” classification, even though the law also classified based on age).

In addition to its sex-based classification, the Treatment Ban also discriminates against a suspect class—transgender persons—and that discrimination independently warrants at least

intermediate scrutiny. Cameron does not meaningfully respond to this argument. He addresses a strawman instead, arguing that “*gender-dysphoric individuals* are not a protected class.” Opp. at 13 (emphasis added). That is not Plaintiffs’ argument. That is not the classification drawn by the Treatment Ban. The Treatment Ban does not use the term “gender dysphoria.” It repeatedly uses the term “sex.” SB 150 § 4. It prohibits the use of hormones and puberty blockers for the purpose of affirming a gender identity that “is inconsistent with” a minor’s natal *sex*. *Id.* As another court observed, the inconsistency described in the Treatment Ban almost perfectly defines a “transgender” person. *Ecknes-Tucker* 603 F. Supp. 3d at 1138.

None of Cameron’s arguments on this issue have merit. Cameron portrays transgender people as unable to contribute to society, (Opp. at 14), but there “is obviously no relationship between transgender status and the ability to contribute to society.” *Dep’t of Educ.*, 208 F. Supp. 3d at 874. Cameron also insists transgender people have political power because activists and medical associations are advocating against the recent onslaught of treatment bans. Opp. at 14. Plainly, such advocacy would be unnecessary if Kentucky and more than a dozen other states had not imposed such bans in the first instance. *See, e.g., Ladapo*, 2023 WL 3833848, at *13.

B. Cameron Cannot Avoid Strict Scrutiny On Plaintiffs’ Due Process Claim.

The Treatment Ban burdens Parent Plaintiffs’ fundamental right to control the care and upbringing of their children by prohibiting them from obtaining medically accepted treatments for their transgender children. *See* Pl. Br. at 22–23; *Kanuszewski v. Mich. Dep’t of Health & Human Servs.*, 927 F.3d 396, 419 (6th Cir. 2019) (“[P]arents’ substantive due process right to make decisions concerning the care, custody, and control of their children includes the right to direct their children’s medical care.”). Plaintiffs do not, as Cameron claims, assert “a fundamental right to obtain whatever drugs they want for their children.” Opp. at 5. Rather, they seek, in consultation with their treating providers, access to medications that are endorsed by “at least twenty-two major

medical associations” as “well-established, evidence-based treatments for gender dysphoria in minors.” *Eknes-Tucker*, 603 F. Supp. 3d at 1145; *cf. Pickup v. Brown*, 740 F.3d 1208, 1224 (9th Cir. 2014) (rejecting parental rights claim where “legislature relied on the well-documented, prevailing opinion of the medical and psychological community” that conversion therapy is ineffective and harmful).² Parents’ fundamental right to direct their children’s medical care includes, at a minimum, the right to obtain these accepted treatments. *See Eknes-Tucker*, F. Supp. 3d at 1146 (parents’ “fundamental right to direct the medical care of their children . . . includes the more specific right to treat their children with transitioning medications subject to medically accepted standards”).

The Commonwealth cannot infringe upon that right based on a generally stated purpose of protecting children or the observation that parental rights have limits. The government’s interest in protecting children does not grant it absolute power to impose its judgment over parents’ objections. “[T]he statist notion that governmental power should supersede parental authority in all cases . . . is repugnant to American tradition.” *Parham*, 442 U.S. at 603.³

If Cameron’s contrary argument were correct, no state restriction on medical care—however unwarranted or extreme—could ever be held to burden parents’ rights to care for and protect their children’s health and well-being. Although states have an interest in protecting health,

² As noted, Parent Plaintiffs do not seek access to experimental medications, like the plaintiffs in *Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 697–98 (D.C. Cir. 2007). They seek treatments that, for many years, have been provided and deemed safe and effective both by medical specialists and the nation’s leading medical and mental health organizations. *See infra.* at § II(C)(3). Barring parents from following such conventional medical advice for their children is a severe intrusion on their parental rights.

³ This fundamental right of parents is not “derivative from” or dependent on a minor’s right to access medical treatment. *Opp.* at 7. A parent’s fundamental right to obtain accepted medical care for a child stands on its own. Indeed, parents have a fundamental right to decide whether their children attend public or private school, *Pierce v. Soc’y of Sisters*, 268 U.S. 510, 535 (1925), even though children have no constitutional right to education, *San Antonio Indep. Dist. v. Rodriguez*, 411 U.S. 1, 35 (1973). In the same way, parents’ right to obtain accepted care for their children exists irrespective of whether children have an underlying right to that medical care.

they must do so within constitutional limits and based on credible evidence. *See, e.g., Roman Catholic Diocese v. Cuomo*, 141 S. Ct. 63, 68 (2020) (enjoining public health order that infringed religious rights where government had “not shown that public health would be imperiled”). Here, Plaintiffs “are likely to prevail on their parental-rights claim” because “there is no rational basis, let alone a basis that would survive heightened scrutiny, for prohibiting these treatments in appropriate circumstances.” *Ladapo*, 2023 WL 3833848, at *11.

C. Cameron’s Proffered Justifications Do Not Withstand Scrutiny.

Every major medical organization, representing every relevant scientific and medical discipline—psychology, psychiatry, endocrinology, and pediatrics—has endorsed well-established protocols for treating adolescents with gender dysphoria. ECF No. 19; ECF No. 17-1 (“Schumer Decl.”) at ¶ 53. Cameron disparages this consensus but fails to support his sharp rhetoric with any credible evidence to justify a ban. As other courts have found, these unsupported claims do not survive any level of review. *Lapado*, 2023 WL 3833848, at *11; *Brandt*, 551 F. Supp. 3d at 891–93; *Eknes-Tucker*, F. Supp. 3d at 1146, 1148; *K.C.*, slip op. 25.⁴

1. Gender dysphoria is a recognized medical condition.

Cameron seeks to justify the Treatment Ban by arguing that adolescents who identify as transgender should be “encouraged” to identify with their natal sex. Opp. at 15–16. Cameron thus insinuates that gender dysphoria is not a legitimate medical diagnosis and that children should be discouraged from being transgender. But gender dysphoria is a recognized medical condition. Children with gender dysphoria are not simply masculine girls or feminine boys, (*see* Expert

⁴ Cameron insinuates repeatedly and without evidence that providers who treat gender dysphoria in minors are improperly motivated by financial gain. Opp. at 1, 16. But Cameron does not argue that the Treatment Ban was intended to prevent profiteering by doctors. Cameron’s references to providers’ supposed financial interests are purely pretextual, not serious attempts to justify the Treatment Ban. “The overwhelming majority of doctors are dedicated professionals whose first goal is the safe and effective treatment of their patients. There is no reason to believe the doctors who adopted these standards were motivated by anything else.” *Ladapo*, 2023 WL 3833848, at *14.

Rebuttal Declaration of Dan H. Karasic, M.D. (“Karasic R-Decl.”) at ¶ 45), and encouraging children to be “confident . . . in their own skin,” (Opp. at 16), is no treatment for gender dysphoria. On the contrary, therapy to change a child’s gender identity is ineffective and harmful. Karasic R-Decl. at ¶ 44. For that reason, every major medical and mental health organization has rejected such therapy as dangerous and unethical. Shumer Decl. at ¶ 27; ECF No. 17-2 (“Janssen Decl.”) at ¶ 20.

2. Adolescents with gender dysphoria overwhelmingly do not “desist.”

Cameron argues that the Treatment Ban is justifiable because “most children with gender dysphoria will desist.” Opp. at 16. That is false. Cameron’s experts misrepresent older studies focused on *prepubertal* children. But the gender-affirming care at issue here is provided only to *adolescents* and gender dysphoria in adolescents does not simply resolve or dissipate without treatment. Rather, “once youth reach the beginning of puberty and identify as transgender, desistance is rare.” Karasic R-Decl. at ¶ 48; Supplemental Expert Declaration of Suzanne Kingery, M.D. (“Kingery S-Decl.”) at ¶ 10; *see also* Rebuttal Declaration of Aron Janssen, M.D. (“Janssen R-Decl.”) at ¶¶ 25-38.

3. Treatments for gender dysphoria are safe and effective.

Cameron is also wrong that treating adolescents with puberty blockers or hormone therapy “causes irreversible harm to their physical and mental health.” Opp. at 16–17. This claim is unsupported by any credible evidence and in fact contradicts the overwhelming consensus of medical experts. “Medical treatment for gender dysphoria has been studied for over half a century, and there is substantial evidence that it improves quality of life and measures of mental health.” Karasic R-Decl. at ¶ 33. Puberty blockers have been safely used to treat precocious puberty for decades, and they are also safe when used to treat gender dysphoria. Shumer Decl. at ¶ 63; Shumer R-Decl. ¶¶ at 19–22; Kingery Decl. at ¶¶ 55–61. Hormone therapy is safely used to treat other

adolescent medical conditions and is also safe when used to treat gender dysphoria. Shumer Decl. at ¶¶ 74-86; Shumer R-Dec. at ¶¶ 34-42; Kingery Decl. at ¶¶ 62-67.

4. The international medical consensus supports the use of puberty blockers and hormone therapy for transgender adolescents.

Cameron falsely claims that an “international consensus is building that there is no reliable evidence to support any of the claims that injecting puberty blockers and cross-sex hormones into children with gender dysphoria is beneficial.” Opp. at 17. To the contrary, as Plaintiffs experts show, there is a strong international medical consensus supporting the use of puberty blockers and hormone therapy to treat gender dysphoria in transgender adolescents. *See, e.g.,* Karasic R-Decl. at ¶¶ 63-67. Further, “no country in Europe—or so far as shown by this record, anywhere in the world—entirely bans these treatments.” *Ladapo*, 2023 WL 3833848, at *14. *At most*, some of the reports Cameron cites advocate for additional research and appropriate guardrails. Moreover, none of the cited reports critique the current WPATH or Pediatric Endocrine Guidelines for determining to whom and how to provide care.

5. Anecdotes do not justify banning established medical care for a serious medical condition.

Cameron submits declarations from former adolescent patients and parents who regret receiving or allowing their children to receive gender-affirming treatment. But these anecdotes do not justify a blanket denial of medical care for all transgender adolescents in Kentucky. Opp. at 18. At most, these anecdotes suggest that some doctors failed to follow standard treatment guidelines, and that like any other medical procedure, treatments for gender dysphoria are not without some risk. A doctor’s failure to meet an established standard of care with a patient may provide grounds for a civil lawsuit, but not a basis for a wholesale ban for all medical providers and their patients.

6. Robust evidence shows the safety and efficacy of medical treatments for gender dysphoria in adolescents.

Relying on his proffered experts, Cameron claims “three systematic, comprehensive research reviews . . . have been conducted concerning the safety and efficacy of puberty blockers and cross-sex hormones as treatments for gender dysphoria in children’ that ‘unanimously concluded the evidence on medicalized transition in minors to be of poor quality.’” Opp. at 19. This reflects a fundamental misunderstanding of systematic reviews. Systematic reviews rate the quality of evidence supporting a particular treatment based on Grading of Recommendations Assessment, Development, and Evaluations (“GRADE”) or a comparable tool. Expert Rebuttal Declaration of Kenneth W. Goodman, Ph.D. (“Goodman R-Decl.”) at ¶¶ 14–15. There is no direct correlation between a GRADE score and whether a treatment is effective or safe, or the strength of a practice recommendation. *Id.* ¶¶ at 16–17; Karasic R-Decl. at ¶¶ 88–92.

Rather, “randomized control trials are initially rated as ‘high quality’ and observational studies as ‘low quality,’” which “does not reflect a condemnation of evidence but rather reflects that the body of peer-reviewed literature in this area is comprised of primarily observational studies.” Goodman R-Decl. at ¶ 17. A “low quality” rating “does not imply the strength of a particular clinical recommendation,” and “low quality studies regularly guide important aspects of clinical practice.” *Id.* Indeed, for most systematic reviews of medical interventions, GRADE scores are low or very low. Karasic R-Decl. at ¶¶ 89–90. It is thus “incoherent to suggest that, in the absence of ‘best-grade’ evidence, clinicians should provide no clinical intervention or treatment at all, especially where there is solid evidence that points in the same direction with respect to showing efficacy of treatment.” Goodman R-Decl. at ¶ 17.

Cameron’s reference to systematic reviews is, therefore, inapposite. The reality is that evidence supporting medical treatments for transgender adolescents is robust and “parallel to

countless other practice guidelines.” *Id.* at ¶ 18.

7. WPATH and the Endocrine Society guidelines are based on evidence.

Cameron’s unsubstantiated attacks on WPATH, the Endocrine Society, and other professional organizations, (*see, e.g.*, Levine Decl. at ¶¶ 61–63; Laidlaw Decl. at ¶ 172), are baseless and not credible. WPATH standards of care have been widely endorsed and adoption by multiple professional organizations and were developed based on a rigorous, evidence-based process comparable to that used in the development of treatment protocols for other medical conditions. Shumer R-Decl. at ¶¶ 9–11 (describing process). As Dr. Karasic notes, “that there are some outlier views . . . does not mean that there is no broad consensus among the larger medical and scientific community about the propriety, safety, and effectiveness of medical care for the treatment of gender dysphoria.” Karasic R-Decl. at ¶ 27.

Dr. Levine, Dr. Cantor, Dr. Laidlaw, and Dr. Nangia disagree with this broad consensus,⁵ but they do not dispute that WPATH guidelines are the widely accepted standard for treating minors with gender dysphoria in the U.S. Cameron nevertheless argues that outlier opinions should be credited over the standards endorsed by reputable medical organizations. He insists, without evidence, that it is a “given” that every reputable medical association in the U.S. is a victim of

⁵ Dr. Cantor, Dr. Laidlaw, and Dr. Levine have testified in multiple cases involving transgender issues to offer their idiosyncratic views, and courts have consistently found their testimony to be of limited value. *See Eknes-Tucker*, 603 F. Supp. 3d at 1142–43 (giving “very little weight” to testimony of Dr. Cantor because “he had never provided care to a transgender minor under the age of sixteen,” “never treated a child or adolescent for gender dysphoria,” and “had no personal knowledge of the assessments or treatment methodologies used at any Alabama gender clinic”); *C.P. ex rel. Pritchard v. Blue Cross Blue Shield*, 2022 WL 17092846, at *4 (W.D. Wash. 2022) (finding Dr. Laidlaw’s expert qualifications were “a close question” because “[l]ess than five percent of his patients are under the age of 18 and he has treated two patients with gender dysphoria,” “[h]e has done no original research on gender identity,” and he “bases his opinions on his general experience as an endocrinologist and a review of literature”); *Edmo v. Idaho Dep’t of Corr.*, 358 F. Supp. 3d 1103, 1125–26 (giving “virtually no weight” to Dr. Levine’s opinion because he is “an outlier in the field of gender dysphoria” who does not “reflect opinions that are generally accepted”), *vacated in part on other grounds*, 935 F.3d 757 (9th Cir. 2019); *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1188 (N.D. Cal. 2015) (giving Dr. Levine’s testimony “very little weight” due to its “illogical inferences, inconsistencies, . . . inaccuracies,” misrepresentation of the Standards of Care, reliance on “generalizations about gender dysphoric [individuals],” and admitted fabrication of anecdotal evidence).

“ideological takeover.” *Id.* at 20. That conspiracy theory is not a “given.” Indeed, “it is fanciful to believe that all the many medical associations who have endorsed gender-affirming care, or who have spoken out or joined an amicus brief supporting the plaintiffs in this litigation, have so readily sold their patients down the river.” *Ladapo*, 2023 WL 3833848, at *14. Rejecting the overwhelming medical consensus is not rational. Nor can it qualify as an exceedingly persuasive justification for a sex-based classification. *See Brandt*, 47 F.4th at 670.

8. There is no evidence that psychotherapy alone is effective.

Cameron seeks to justify banning all medical treatments for gender dysphoria by claiming that “[t]here are other, better ways of treating gender dysphoria, like psychotherapy, ... that can identify other mental health issues that may be the true catalyst for gender dysphoria.” This assertion is baseless. As Plaintiffs have shown, psychotherapy alone does not effectively treat gender dysphoria in adolescents, (*see, e.g.*, Kingery R- Decl. at ¶ 12), and there is no evidence that gender dysphoria is a symptom of other mental health conditions. Janssen R-Decl. at ¶¶ 59-63.

9. Minors can provide informed assent to treatment.

Cameron incorrectly claims that “a child cannot provide informed consent to puberty blocker or hormones.” *Opp.* at 22. Parents, not minor patients, must consent to medical care for their children; the minor patients must assent. Shumer R.-Decl. at ¶ 48. Minors make these decisions with guidance and support from their medical providers and parents. The WPATH standard “outlines criteria for how providers obtain assent and consent for medical intervention,” to ensure that parents and patients understand the risks and benefits. *Id.* at ¶ 48; Kingery Decl. at ¶¶ 33–34. These decisions are not “different than other complex medical decisions that parents and guardians make regarding the health and wellness of their children every day.” Shumer R.-Decl. at ¶ 48.

In sum, Cameron has not shown that any of his asserted justifications for the Treatment Ban is supported by evidence sufficient to survive rational-basis review, much less the heightened or strict scrutiny required here. Cameron also cannot show that completely banning all medical treatment for transgender adolescents is narrowly tailored or substantially related to an asserted interest in protecting youth. To the contrary, there are multiple alternatives, such as requiring providers to follow the standard of care or ensuring that providers obtain written informed consent, that would address any legitimate concerns without entirely depriving transgender adolescents of any ability to obtain essential and in some instances potentially lifesaving care.

II. A PRELIMINARY INJUNCTION AGAINST ALL ENFORCEMENT OF THE TREATMENT BAN IS NECESSARY TO PROTECT PLAINTIFFS.

Plaintiffs' strong likelihood of success on the merits satisfies the remaining conditions for a preliminary injunction. "When reviewing a motion for a preliminary injunction, if it is found that a constitutional right is being threatened or impaired, a finding of irreparable injury is mandated." *Bonnell v. Lorenzo*, 241 F.3d 800, 809 (6th Cir. 2001). Indeed, Cameron makes no real effort to show that Plaintiffs will not be irreparably harmed without an injunction. Cameron instead posits that Plaintiffs would be irreparably harmed *by an injunction*. That unusual argument is founded on the false and unsupported premise that treatment with puberty blockers and hormone therapy is harmful. Plaintiffs and their doctors have concluded otherwise, and their opinion is controlling. *See Blakley v. Comm'r of Soc. Sec.*, 581 F.3d 399, 408 (6th Cir. 2009) (treating physician opinion given "controlling weight" "absent justifiable reason . . . for discounting those opinions").

Because Plaintiffs have shown a likelihood of success on the merits, a preliminary injunction enjoining enforcement of the Treatment Ban is warranted. *See Bassett v. Snyder*, 951 F. Supp. 2d 939, 972–73 (E.D. Mich. 2013) (noting, in an equal protection challenge, that "[t]o provide effective relief, the injunction must prohibit the defendant from enforcing" the challenged

act, as “[a]n injunction applicable only to the named plaintiffs would be impractical and difficult to enforce”). Cameron’s arguments for a more limited injunction specific to Plaintiffs makes no sense. The Treatment Ban constrains *medical providers* by threatening their licenses, and those providers treat the Minor Plaintiffs *and others*. If defendants must enforce the ban against those providers for treating others, as Cameron suggests, then Plaintiffs will suffer irreparable harm. A blanket injunction against enforcement is thus necessary to afford relief *to Plaintiffs*.

Injunctions are not improper simply because they benefit non-parties. *See, e.g., Washington v. Reno*, 35 F.3d 1093, 1104 (6th Cir. 1994) (“Because relief for the named plaintiffs in the case would also necessarily extend to all federal inmates, the district court did not err in granting wide-ranging injunctive relief.”). “Facial unconstitutionality as to one means facial unconstitutionality as to all, regardless of the fact that the injunctive portion of the judgment directly adjudicated the dispute of only the parties before it.” *Mulholland v. Marion Cnty. Elec. Bd.*, 746 F.3d 811, 819 (7th Cir. 2014).

CONCLUSION

For the forgoing reasons and the reasons stated in Plaintiffs’ original motion, Plaintiffs’ motion should be granted.

Dated: June 16, 2023

Respectfully Submitted,

/s/ Stephanie Schuster

Stephanie Schuster (pro hac vice)

Randall M. Levine (pro hac vice)

MORGAN, LEWIS & BOCKIUS LLP

1111 Pennsylvania Ave., NW

Washington, DC 20004-2541

(202) 739-3000

stephanie.schuster@morganlewis.com

randall.levine@morganlewis.com

Amanda J. Ford (pro hac vice)

MORGAN, LEWIS & BOCKIUS LLP

One Federal Street

Boston, MA 02110-1726

(617) 431-7700

amanda.ford@morganlewis.com

Corey Shapiro

Heather Gatnarek

Crystal Fryman

Kevin Muench

ACLU OF KENTUCKY FOUNDATION

325 W. Main St. Suite 2210

Louisville, KY 40202

(502) 581-9746

corey@aclu-ky.org

heather@aclu-ky.org

crystal@aclu-ky.org

kevin@aclu-ky.org

Christopher F. Stoll (pro hac vice)

Kelly Jo Popkin (pro hac vice)

NATIONAL CENTER FOR LESBIAN RIGHTS

870 Market Street, Suite 370

San Francisco, CA 94102

(415) 365-1320

cstoll@nclrights.org

kpopkin@nclrights.org

Counsel for Plaintiffs

CERTIFICATE OF SERVICE

The undersigned certifies that the foregoing was filed with the Court using the CM/ ECF system on June 16, 2023, which will generate an electronic notice of filing to all counsel registered with that service.

/s/ Stephanie Schuster _____
Stephanie Schuster

Exhibit 1

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K. C., *et al.*)
)
 Plaintiffs,)
)
 v.) No. 1:23-cv-00595-JPH-KMB
)
 THE INDIVIDUAL MEMBERS OF THE)
 MEDICAL LICENSING BOARD OF)
 INDIANA in their official capacities, *et al.*)
)
 Defendants.)

**ORDER GRANTING IN PART PLAINTIFFS' MOTION
FOR A PRELIMINARY INJUNCTION**

Recently enacted by the Indiana General Assembly, Senate Enrolled Act 480 is scheduled to become effective July 1, 2023. If it takes effect, S.E.A. 480 will prohibit physicians and other practitioners from knowingly providing gender transition procedures to a minor, and from aiding or abetting another physician or practitioner in the provision of gender transition procedures to a minor. Gender transition procedures banned by S.E.A. 480 include the use of puberty-blocking drugs, cross-sex hormone therapy, and gender reassignment surgery. Plaintiffs are four minor children, many of their parents, and a doctor and her family medical practice. Alleging that S.E.A. 480 violates the United States Constitution and other federal laws, Plaintiffs ask the Court to enter a preliminary injunction that would prohibit Defendants—who are various State officials—from enforcing S.E.A. 480.

The State has a strong interest in enforcing democratically enacted laws. And Defendants have shown that there are important reasons underlying the

State's regulation of gender transition procedures for minors. Still, Plaintiffs have carried their burden of showing some likelihood of success on their claims that S.E.A. 480 would violate their equal protection rights under the Fourteenth Amendment and free speech rights under the First Amendment. Under the evidence available at this preliminary stage, there is not a "close means-end fit" between the State's important reasons for regulating the provision of gender transition procedures to minors and S.E.A. 480's broad ban of those procedures. So, when the State's interests are weighed against the likelihood that Plaintiffs will be able to show that S.E.A. 480 would violate their constitutional rights and the risk of irreparable harm, Plaintiffs are entitled to a preliminary injunction.

Plaintiffs' motion for a preliminary injunction is therefore **GRANTED in part** to the extent that, while this case is pending, Defendants may not enforce S.E.A. 480's prohibitions on (1) providing gender transition procedures for minors except gender reassignment surgery and (2) speech that would aid or abet gender transition procedures for minors. Dkt. [9]. Plaintiffs motion is **DENIED in part** as to the ban on gender reassignment surgeries. Plaintiffs lack standing to challenge that ban because gender reassignment surgeries are not provided to minors in Indiana.

I. Facts & Background

The parties have submitted joint stipulated facts, dkt. 51, and more than 3,000 pages of evidence. Dkt. 26; dkt. 48; dkt. 49; dkt. 58. They also jointly recommended to the Court that there was no need for an evidentiary hearing,

see dkt. 22 at 3; dkt. 56, so the Court's recitation of the relevant facts is based on the written materials submitted with the parties' briefing.

A. Sex, gender, and gender dysphoria

A person's sex is generally identified at birth based on external genitalia. Dkt. 51 at 1 (parties' stipulated facts). Gender or gender identity, by contrast, commonly refer to a person's psychological and/or cultural sense of their sex or gender. Dkt. 26-1 at 7 (Karasic decl.); dkt. 48-2 at 12–13 (Hruz report). Most people's sex and gender identity match, but "[f]or transgender people, their assigned sex does not align with their gender identity." Dkt. 26-1 at 7 (Karasic decl.).

Gender dysphoria is a mental-health diagnosis recognized in the Fifth Edition of the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders ("DSM-5"), and can be diagnosed in pre-pubertal children, adolescents, or adults. Dkt. 51 at 2–3. The DSM-5 defines gender dysphoria as "[a] marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by" certain diagnostic criteria. *Id.* Gender dysphoria in adolescents or adults "is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning." *Id.* at 3.

"There is no medical or surgical treatment indicated for children with gender dysphoria pre-puberty." *Id.* at 4. However, once puberty begins, "[a]dolescents diagnosed with gender dysphoria . . . may be prescribed puberty-delaying medications." Dkt. 26-2 at 13 (Shumer decl.). Then, in mid-

adolescence, patients may be prescribed hormones—testosterone, or estrogen with a testosterone suppressant. *Id.* at 16. Gender-transition surgeries may also be considered, *see* *dk.* 26-3 at 7 n.11 (Turban decl.), but in Indiana no "provider performs gender-transition surgery on persons under the age of 18." *Dkt.* 51 at 4.

B. Senate Enrolled Act 480

In early 2023, the Indiana General Assembly passed S.E.A. 480 and Governor Holcomb signed it into law. S.E.A. 480 (to be codified at Ind. Code §§ 25-1-22-1 *et seq.* (eff. July 1, 2023)).

S.E.A. 480 would prohibit physicians and other medical practitioners from "knowingly provid[ing] gender transition procedures to a minor." S.E.A. 480 § 13(a). The statute defines "gender transition" as "the process in which an individual shifts from identifying with and living as a gender that corresponds to his or her sex to identifying with and living as a gender different from his or her sex." *Id.* § 3. It defines "sex" as "the biological state of being male or female, based on the individual's sex organs, chromosomes, and endogenous hormone profiles." *Id.* § 12. And "gender" as "the psychological, behavioral, social, and cultural aspects of being male or female." *Id.* § 1.

Under S.E.A. 480, the prohibited "gender transition procedures" include "any medical or surgical service . . . that seeks to:

- (1) alter or remove physical or anatomical characteristics or features that are typical for the individual's sex; or

(2) instill or create physiological or anatomical characteristics that are different from the individual's sex."

Id. § 5(a). The statute then excludes:

(1) Medical or surgical services to an individual born with a medically verifiable disorder of sex development, including an individual with:

(A) external sex characteristics that are irresolvably ambiguous;

(B) forty-six (46) XX chromosomes with virilization;

(C) forty-six (46) XY chromosomes with undervirilization; or

(D) both ovarian and testicular tissue.

(2) Medical or surgical services provided when a physician or practitioner has diagnosed a disorder or condition of sexual development that the physician or practitioner has determined through genetic or biochemical testing that the individual does not have normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action.

(3) The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of gender transition procedures.

(4) Any medical or surgical service undertaken because the individual suffers from a physical disorder, physical injury, or physical illness that would, as certified by the physician or practitioner, place the individual in imminent danger of death or impairment of major bodily function unless the medical or surgical service is performed.

(5) Mental health or social services other than gender transition procedures as defined in subsection (a).

(6) Services for a disorder or condition of sexual development that is unrelated to a diagnosis of gender dysphoria or gender identity disorder.

Id. § 5(b), *see* § 13(c).

Medical services prohibited under S.E.A. 480 can thus include "medical services that provide puberty blocking drugs, gender transition hormone therapy, or genital . . . or nongenital gender reassignment surgery." *Id.* § 5(a)(2).¹ Physicians and other medical practitioners are further prohibited from "aid[ing] or abet[ting] another physician or practitioner in the provision of" prohibited gender transition procedures to a minor. *Id.* § 13(b).

Physicians or medical practitioners who violate S.E.A. 480 are subject to discipline by their regulating licensing boards. *Id.* § 15; Ind. Code § 25-1-9-4(a)(3) (providing for discipline for licensed medical providers who "knowingly violate[] any state statute . . . regulating the profession in question"). Private individuals may also bring lawsuits alleging violations of S.E.A. 480. S.E.A. 480 § 17.

C. Plaintiffs

K.C. is the ten-year-old child of Nathaniel and Beth Clawson. *See* dkt. 51 at 5. "K.C. was identified male at birth," but before the age of 4 "grabbed a pair of scissors, and asked to cut off K.C.'s penis, asserting that it should not be there." *Id.* An IU Health pediatrician diagnosed K.C. with gender dysphoria. *Id.* K.C. "socially transitioned [to female] before K.C. was 4 years old and uses female pronouns." *Id.* In 2017, K.C. first visited the Riley Gender

¹ S.E.A. 480 provides a limited extension to its July 1, 2023 effective date: physicians or medical practitioners may "continue to prescribe . . . until December 31, 2023," gender transition hormone therapy to individuals who were taking that therapy "on June 30, 2023, as part of a gender transition procedure." S.E.A. 480 § 13(d).

Health Clinic, which "again diagnosed [K.C.] with gender dysphoria." *Id.* at 6. K.C. began taking a puberty blocker in 2023. *Id.*

M.W. is the 16-year-old child of Ryan and Lisa Welch. *Id.* "M.W. was identified female at birth" and "was diagnosed with gender dysphoria in adolescence." *Id.* at 6–7. At the age of 12, M.W. "declared that M.W. is a transgender male" and now "uses a stereotypically male first name and male pronouns." *Id.* at 7. "M.W. was prescribed testosterone" in July 2022, and continues to receive testosterone. *Id.* at 7.

A.M. is the 11-year-old child of Emily Morris. *Id.* at 8. "At birth, A.M. was identified as male," but "[b]efore A.M. was 4 years of age, A.M. stated to family members that A.M. was a girl and was thinking about trying to cut off A.M.'s penis." *Id.* "A.M. socially transitioned before the age of 4" and since then "has used a stereotypically female first name and female pronouns." *Id.* A.M. has been diagnosed with gender dysphoria and receives a puberty blocker. *Id.* at 9-10.

M.R. is the 15-year-old child of Maria Rivera. *Id.* at 10. "M.R. was identified as female at birth" and in December 2021 "declared . . . that M.R. is a transgender male." *Id.* "M.R. now consistently uses a stereotypically male first name and male pronouns." *Id.* M.R. has been diagnosed with gender dysphoria and receives testosterone under a prescription from Dr. Catherine Bast at Mosaic Health and Healing Arts ("Mosaic"). *Id.* at 11.

Dr. Bast is a board-certified family-practice physician at Mosaic in Goshen, Indiana. *Id.* at 11–12. Mosaic currently treats 72 minor patients who

are diagnosed with gender dysphoria and are prescribed either puberty blockers or hormones. *Id.* at 12.

D. Defendants

The individual members of the Medical Licensing Board of Indiana serve as members of the board that is responsible for the licensing and discipline of medical providers, and that grants and revokes licenses to Indiana medical practitioners. *See* *dk.* 1 at 5; Ind. Code §§ 25-1-9-1 *et seq.*

The Executive Director of the Indiana Professional Licensing Agency oversees the Medical Licensing Board. Ind. Code §§ 25-0.5-3-1 *et seq.*; 25-1-6-3.

The Attorney General of Indiana investigates complaints against licensed medical providers and can pursue discipline from the Medical Licensing Board. Ind. Code § 25-1-7-2.

The Secretary of Indiana Family and Social Services Administration is the director of the FSSA, which administers Medicaid in Indiana. Ind. Code § 12-15-1-1.

E. Procedural history and preliminary-injunction evidence

Plaintiffs brought this action in April 2023, alleging that S.E.A. 480's restrictions violate (1) the minor plaintiffs' Fourteenth Amendment equal protection rights; (2) the parent plaintiffs' "fundamental rights protected by due process" under the Fourteenth Amendment, (3) the medical-provider plaintiffs' First Amendment speech rights; and (4) Medicaid provisions in 42 U.S.C. §§ 18116 and 1396d(a). *Dkt.* 1 at 42–45. Plaintiffs have filed a motion for a

preliminary injunction under Federal Rule of Civil Procedure 65, requesting that the Court "prohibit[] the enforcement of" S.E.A. 480. Dkt. 9.

The parties have agreed that there should not be an evidentiary hearing. See dkt. 22 at 3; dkt. 56. To develop the preliminary-injunction record, the parties have conducted substantial discovery, filed a statement of stipulated facts, and designated extensive evidence. See dkt. 26; dkt. 48; dkt. 49; dkt. 51. In total, excluding citations and supporting exhibits, Plaintiffs have designated more than 100 pages of expert opinions, dkt. 26; dkt. 58, and Defendants have designated more than more than 300 pages of expert opinions, dkt. 48. The parties' complete evidentiary filings span more than 3,000 pages. Dkt. 26; dkt. 48; dkt. 49; dkt. 58.

Despite the volume of designated evidence and the contradicting expert opinions, the parties have designated only a small portion of the evidentiary filings in their briefs, generally relying on summaries of evidence in their experts' reports. See dkt. 54; dkt. 59.

1. Plaintiffs' experts

Plaintiffs have designated three experts, who have provided reports of their opinions.

Dr. Dan Karasic, a Professor Emeritus of Psychiatry at the University of California, San Francisco School of Medicine, has "provided care for thousands of transgender patients" over thirty years. Dkt. 26-1 at 3. He's worked with the World Professional Association for Transgender Health ("WPATH") and co-authored the *WPATH Standards of Care for the Health of Transsexual,*

Transgender, and Gender Nonconforming People. *Id.* at 4. Dr. Karasic's expert report details his opinions on gender identity, gender dysphoria, appropriate medical treatments, and harms of denying gender-affirming care. *Id.* at 6–18.

Dr. Daniel Shumer is a pediatric endocrinologist, an Associated Professor of Pediatrics at Mott Children's Hospital at Michigan Medicine, and the Medical Director of the Comprehensive Gender Services Program at Michigan Medicine, University of Michigan. Dkt. 26-2 at 1. He has extensively researched "gender identity in pediatrics and the treatment of gender dysphoria" and has "been treating patients with gender dysphoria as a pediatric endocrinologist since 2015." *Id.* at 2. Dr. Shumer's expert report addresses evidence-based treatments for gender dysphoria in minors, including their safety and efficacy. *Id.* at 6–23.

Dr. Jack Turban is an Assistant Professor of Child & Adolescent Psychiatry at the University of California, San Francisco School of Medicine and the director of the Gender Psychiatry Program in the Division of Child & Adolescent Psychiatry. Dkt. 26-3 at 2. His expert report includes opinions about the effects of gender-dysphoria treatment on mental health. *Id.* at 4–18.

Plaintiffs' experts have each filed supplemental reports addressing the opinions of Defendants' experts. Dkt. 58. Defendants have filed a motion to exclude many of the opinions from Plaintiffs' experts, arguing that they are unreliable. *See* dkt. 62; dkt. 63.²

² Plaintiffs have orally moved to strike that motion because it violates the parties' stipulation regarding the admissibility of evidence discussed at the June 5, 2023 status conference, *see* dkt. 56, and was filed too late in the preliminary-injunction

2. Defendants' experts

Defendants have designated five experts, who have provided reports detailing their opinions.

Dr. James Cantor is the Director of the Toronto Sexuality Centre. Dkt. 48-1 at 9. He is trained as a clinical psychologist and neuroscientist and has researched "the development of sexual orientation, gender identity, hypersexuality, and atypical sexualities." *Id.* at 8. His expert report opines on the strength of the medical evidence regarding gender-dysphoria treatments as well as the safety and effectiveness of those treatments. *Id.* at 11–131.

Dr. Paul Hruz, an Associate Professor of Pediatrics in the Division of Pediatric Endocrinology and Diabetes at Washington University School of Medicine, has "participated in the care of hundreds of infants and children, including adolescents, with disorders of sexual development." Dkt. 48-2 at 2. Dr. Hruz's opinions address the use of puberty blockers and hormone therapy to treat endocrine disorders and gender dysphoria. *Id.* at 9–52.

Dr. Dianna Kenny was a Professor of Psychology at the University of Sydney for thirteen years and is now "a psychodynamic psychotherapist" and "child, marriage, and family therapist." Dkt. 48-3 at 3-4. For the past five years, she has "engaged in exploratory psychotherapy with children,

proceedings. Many of the points raised in support of Defendants' motion to exclude could and should have been made in their response brief. Dkt. 54. This case's preliminary-injunction proceedings have been carefully scheduled to ensure thorough and fair review before S.E.A. 480's July 1, 2023 effective date, and none of those orders anticipated a motion to exclude filed after preliminary-injunction briefing was complete. *See* dkt. 21; dkt. 25; dkt. 56. However, for the reasons below, it's unnecessary to strike Defendants' motion to exclude.

adolescents, and their families who are struggling with gender dysphoria." *Id.* at 4. Dr. Kenney's report addresses social aspects of gender dysphoria. *Id.* at 10–126.

Dr. Daniel Weiss, a practicing endocrinologist, has provided care for adults and children, and has completed extensive medical research. Dkt. 48-4 at 3. He opines on the history and safety of treatments for gender dysphoria. *Id.* at 5–30.

Dr. Kristopher Kaliebe is an Associate Professor in the University of South Florida Medical School's Department of Psychiatry. Dkt. 48-5 at 3. He supervises a child and adolescent psychiatry clinic and treats pediatric patients with gender dysphoria. *Id.* at 7. His expert report opines on the history of gender dysphoria diagnoses and the strength of the evidence regarding gender-dysphoria treatments. *Id.* at 10–71.

The Court held oral argument on June 14, 2023. Dkt. 66.

II. Preliminary Injunction Standard

Injunctive relief under Federal Rule of Civil Procedure 65 is "an exercise of very far-reaching power, never to be indulged in except in a case clearly demanding it." *Cassell v. Snyders*, 990 F.3d 539, 544 (7th Cir. 2021). To obtain such extraordinary relief, the party seeking the preliminary injunction carries the burden of persuasion by a clear showing. *See id.*; *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997).

Determining whether a plaintiff "is entitled to a preliminary injunction involves a multi-step inquiry." *Int'l Ass'n of Fire Fighters, Local 365 v. City of E.*

Chi., 56 F.4th 437, 446 (7th Cir. 2022). "As a threshold matter, a party seeking a preliminary injunction must demonstrate (1) some likelihood of succeeding on the merits, and (2) that it has no adequate remedy at law and will suffer irreparable harm if preliminary relief is denied." *Id.* "If these threshold factors are met, the court proceeds to a balancing phase, where it must then consider: (3) the irreparable harm the non-moving party will suffer if preliminary relief is granted, balancing that harm against the irreparable harm to the moving party if relief is denied; and (4) the public interest, meaning the consequences of granting or denying the injunction to non-parties." *Cassell*, 990 F.3d at 545. This "involves a 'sliding scale' approach: the more likely the plaintiff is to win on the merits, the less the balance of harms needs to weigh in his favor, and vice versa." *Mays v. Dart*, 974 F.3d 810, 818 (7th Cir. 2020). "In the final analysis, the district court equitably weighs these factors together, seeking at all times to minimize the costs of being mistaken." *Cassell*, 990 F.3d at 545.

III. Analysis

A. Standing to challenge S.E.A. 480's prohibition on gender reassignment surgery

Gender reassignment surgery is one of the "gender transition procedures" that S.E.A. 480 prohibits for minors. S.E.A. 480 §§ 5(a); 13(a). The statute defines "gender reassignment surgery" as "any medical or surgical service that seeks to surgically alter or remove healthy physical or anatomical characteristics or features that are typical for the individual's sex, in order to instill or create physiological or anatomical characteristics that resemble a sex

different from the individual's sex . . . knowingly performed for the purpose of assisting an individual with a gender transition." *Id.* § 2.

The parties have stipulated that "[n]o Indiana provider performs gender-transition surgery on persons under the age of 18." Dkt. 51 at 4. Defendants therefore argue that Plaintiffs lack standing to seek a preliminary injunction against S.E.A. 480's prohibition on gender-transition surgery. Dkt. 54 at 30. Plaintiffs contend that they have standing because they are challenging the prohibition on "gender transition procedures' generally." Dkt. 59 at 22.

Standing is a constitutional doctrine "rooted in the traditional understanding of a case or controversy" and "ensure[s] that federal courts do not exceed their authority as it has been traditionally understood." *Spokeo, Inc. v. Robins*, 578 U.S. 330, 337–38 (2016); U.S. CONST. Art. III, § 2. To have standing, a plaintiff "must have (1) suffered an injury in fact, (2) that is fairly traceable to the challenged conduct of the defendant, and (3) that is likely to be redressed by a favorable judicial decision." *Spokeo*, 578 U.S. at 338. Here, Plaintiffs must have standing as to each piece of their claim. *See Johnson v. U.S. Office of Pers. Mgmt.*, 783 F.3d 655, 661 (7th Cir. 2015) ("The fact that a plaintiff has suffered an injury that is traceable to one kind of conduct does not grant that plaintiff standing to challenge other, even related, conduct; standing is not dispensed in gross."); *Mueller v. Raemisch*, 740 F.3d 1128, 1132–33 (7th Cir. 2014) (holding that the plaintiffs had standing to challenge the requirement to continually update sex-offender registry information, but not to challenge the prohibition on changing their names, since they had no intention

of doing so). "To have standing for prospective injunctive relief, a plaintiff must face a 'real and immediate' threat of future injury as opposed to a threat that is merely 'conjectural or hypothetical.'" *Simic v. City of Chicago*, 851 F.3d 734, 738 (7th Cir. 2017); *see Speech First, Inc. v. Killeen*, 968 F.3d 628, 638 (7th Cir. 2020) (recognizing a plaintiff's "burden to demonstrate standing in the context of a preliminary injunction motion"). Put simply, a preliminary injunction can be appropriate only if there are "continuing, present adverse effects." *Simic*, 851 F.3d at 738.

Here, the stipulated facts show that no minor could receive gender-transition surgery from a physician or other practitioner in Indiana, regardless of S.E.A. 480. Dkt. 51 at 4. Plaintiffs therefore cannot show that S.E.A. 480's prohibition on gender-transition surgery would cause any minor in Indiana an injury that is likely to be redressed by a favorable judicial decision. Plaintiffs therefore lack standing to seek a preliminary injunction against S.E.A. 480's prohibition on gender-transition surgery for minors. *See Speech First*, 968 F.3d at 644.

B. Fourteenth Amendment equal protection claims

"The Fourteenth Amendment's Equal Protection Clause guarantees that 'No State shall . . . deny to any person within its jurisdiction the equal protection of the laws.'" *Hope v. Comm'r of Ind. Dep't of Corr.*, 9 F.4th 513, 528–29 (7th Cir. 2021) (quoting U.S. CONST. amend. XIV, § 1). This "is essentially a direction that all persons similarly situated should be treated alike." *Whitaker v. Kenosha Unified Sch. Dist. No. 1*, 858 F.3d 1034, 1050 (7th Cir. 2017).

Plaintiffs argue that S.E.A. 480 "violates the equal protection rights of the plaintiff youth" because it impermissibly "discriminates on the basis of both sex and transgender status." Dkt. 27 at 26–27. Defendants respond that S.E.A. 480 instead makes reasonable classifications "based on age, procedure, and condition—not sex or transgender status." Dkt. 54 at 40.

1. Sex-based classifications and heightened scrutiny

"Generally, state action is presumed to be lawful [under the Equal Protection Clause] and will be upheld if the classification drawn by the statute is rationally related to a legitimate state interest." *Whitaker*, 858 F.3d at 1050. That "rational basis test, however, does not apply when a classification is based upon sex." *Id.* Sex-based classifications are instead "subject to heightened scrutiny," requiring "the state to demonstrate that its proffered justification is 'exceedingly persuasive.'" *Id.*; accord *Sessions v. Morales–Santana*, 582 U.S. 47, 59 (2017) (recognizing "the heightened scrutiny that now attends 'all gender-based classifications'"). "This requires the state to show that the 'classification serves important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives.'" *Whitaker*, 858 F.3d at 1050 (quoting *United States v. Virginia*, 518 U.S. 515, 524 (1996)).

Plaintiffs argue that heightened scrutiny applies here because, under S.E.A. 480, sex is the determining factor as to whether a treatment is prohibited. Dkt. 27 at 27–30. Defendants respond that S.E.A. 480 draws

distinctions based on other factors, such as medical condition and procedure, rather than based on sex. Dkt. 54 at 40.

S.E.A. 480 defines "sex" as "the biological state of being male or female, based on the individual's sex organs, chromosomes, and endogenous hormone profiles." S.E.A. 480 § 12. And it prohibits "a physician or other practitioner" from "knowingly provid[ing] gender transition procedures to a minor." *Id.* § 13(a). "[G]ender transition" is defined as "the process in which an individual shifts from identifying with and living as a gender that corresponds to his or her sex to identifying with and living as a gender different from his or her sex." *Id.* § 3. And a "gender transition procedure" is defined as:

any medical or surgical service . . . that seeks to:

- (1) alter or remove physical or anatomical characteristics or features that are typical for the individual's sex; or
- (2) instill or create physiological or anatomical characteristics that resemble a sex different from the individual's sex, including medical services that provide puberty blocking drugs, gender transition hormone therapy, or genital gender reassignment surgery or nongenital gender reassignment surgery knowingly performed for the purpose of assisting an individual with a gender transition.

Id. § 5(a).

Sex-based classifications are therefore central to S.E.A. 480's prohibitions. Section 5(a)(1), for example, prohibits procedures seeking to "alter or remove physical or anatomical characteristics or features that are typical for the individual's sex." But it does not prohibit a person from seeking to "alter or remove" a characteristic or feature typical of the opposite sex, under

S.E.A. 480's definition of sex. Similarly, section 5(a)(2) prohibits the creation of physiological or anatomical characteristics or features "that resemble a sex different from the individual's sex." But it does not prohibit a medical provider from creating physiological or anatomical characteristics or features that resemble that individual's sex. In other words, the statute allows physicians and other practitioners to "instill or create" characteristics "resembl[ing]" female anatomical characteristics for females but not for males, and male anatomical characteristics for males but not for females. It's therefore impossible for a medical provider to know whether a treatment is prohibited without knowing the patient's sex. S.E.A. 480's prohibitions therefore "cannot be stated without referencing sex." *Whitaker*, 858 F.3d at 1051.

Despite that statutory language, Defendants argue that S.E.A. 480's classifications are instead "based on age, procedure, and medical condition" and "encompass both sexes and all gender identities." Dkt. 54 at 40. Defendants therefore contend that because S.E.A. 480 prohibits all gender-transition procedures, for both males and females, there's no sex-based classification. *See id.* at 40–41 (relying on *Geduldig v. Aiello*, 417 U.S. 484 (1974)). But *Geduldig* was about pregnancy, which doesn't always trigger heightened scrutiny since it's an "objectively identifiable physical condition" and not necessarily a proxy for sex, even though "only women can become pregnant." 417 U.S. at 496 n.20. S.E.A. 480's prohibitions, by contrast, do not prohibit certain medical procedures in all circumstances, but only when used for gender transition, which in turn requires sex-based classifications.

Indeed, under S.E.A. 480's plain language, a medical provider can't know whether a gender *transition* is involved without knowing the patient's sex and the gender associated with the goal of the treatment. S.E.A. 480 § 3, 5(a).

In short, without sex-based classifications, it would be impossible for S.E.A. 480 to define whether a puberty-blocking or hormone treatment involved transition from one's sex (prohibited) or was in accordance with one's sex (permitted). That's certainly why S.E.A. 480's plain text defines "sex," *id.* § 12; defines "gender transition" in sex-based terms, *id.* § 3; and then phrases its prohibitions in terms that repeatedly rely on those definitions, *id.* §§ 5(a), 13(a) (prohibitions centering on what is "typical for the individual's sex" and "characteristics that resemble a sex different from the individual's sex"). At bottom, sex-based classifications are not just present in S.E.A. 480's prohibitions; they're determinative.

Defendants further argue that the rationale for heightened scrutiny doesn't apply to S.E.A. 480. Dkt. 54 at 31–33 (arguing that when "medical procedures take account of basic, immutable biological differences" between males and females, that does not trigger heightened scrutiny and does not rely on "stereotypes"). The Supreme Court has indeed applied heightened scrutiny while recognizing that "[p]hysical differences between men and women are enduring" and that "[t]he two sexes are not fungible." *United States v. Virginia*, 518 U.S. 515, 533 (1996). It has therefore explained that the purpose of heightened scrutiny is not to "make sex a proscribed classification" but to ensure that sex-based classifications do not "create or perpetuate the legal,

social, and economic inferiority of women" or men. *Id.*; *Sessions*, 582 U.S. at 72.

While S.E.A. 480 prohibits both male and female minors from using puberty blockers and cross-sex hormone therapy for gender transition, it nonetheless draws sex-based classifications under current Seventh Circuit precedent. *See Whitaker*, 858 F.3d at 1050. For the reasons argued by Defendants, perhaps the Seventh Circuit or the Supreme Court will hold that a legislative sex-based classification like that made in S.E.A. 480 is presumed lawful and subject to only rational basis review. But *Whitaker* holds that rational basis review "does not apply when a classification is based upon sex." 858 F.3d at 1050. Instead, a sex-based classification triggers heightened scrutiny that requires the state to show that the "classification serves important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives." *Id.*

The Eighth Circuit reached the same conclusion in a case involving a substantially similar statute. *Brandt v. Rutledge*, 47 F.4th 661 (8th Cir. 2022). There, the court held that heightened scrutiny applied to the challenged Arkansas statute because "[t]he biological sex of the minor patient is the basis on which the law distinguishes between those who may receive certain types of medical care and those who may not." *Id.* at 670. The same is true here.

Because S.E.A. 480's prohibitions are "inherently based upon" sex classifications, "heightened review applies." *Whitaker*, 858 F.3d at 1051.³

2. Heightened scrutiny applied to S.E.A. 480

"Successful defense of legislation that differentiates on the basis of gender . . . requires an 'exceedingly persuasive justification.'" *Sessions v. Morales-Santana*, 582 U.S. 47, 58 (2017). "For a gender-based classification to withstand such scrutiny, it must 'serve important governmental objectives,' and 'the discriminatory means employed must be substantially related to the achievement of those objectives.'" *Nevada Dep't of Human Res. v. Hibbs*, 538 U.S. 721, 728–29 (2003) (quoting *Virginia*, 518 U.S. at 533). In other words, there must be a "close means–end fit." *Sessions*, 582 U.S. at 68.

Plaintiffs argue that S.E.A. 480 does not survive heightened scrutiny because there's no important government interest to justify prohibiting "safe, effective, and medically necessary treatment for the health and well-being of adolescents suffering from gender dysphoria." Dkt. 27 at 30. Defendants contend that the prohibited treatments are unsafe and their effectiveness is unproven, so S.E.A. 480 is justified by the State's interests in protecting the wellbeing of minors and regulating the medical profession. Dkt. 54 at 33–40.

Certainly, the proffered state interests are legitimate. "[I]t is clear that a legislature may pass valid laws to protect children." *Packingham v. North Carolina*, 582 U.S. 98, 106 (2017). And it's similarly "clear [that] the State has

³ Because S.E.A. 480's sex-based classification triggers heightened scrutiny, the Court does not address what level of scrutiny a transgender-based classification alone might warrant.

a significant role to play in regulating the medical profession." *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007). But heightened scrutiny requires a "close means–end fit," so it's not enough for the State's interests to justify *some* regulation of gender transition procedures for minors. Instead, the State's interests must justify S.E.A. 480's *prohibition* of gender transition procedures for minors. *Sessions*, 582 U.S. at 68; *cf. Packingham*, 582 U.S. at 106 (explaining, in the First Amendment context, that "the assertion of a valid governmental interest cannot, in every context, be insulated from all constitutional protections").

S.E.A. 480's scope is broad. As Defendants acknowledge, the statute "generally prohibits licensed medical providers from knowingly providing, or aiding and abetting another practitioner in providing, gender transition procedures to a minor." Dkt. 54 at 27–28. Indiana thus opted to ban—rather than otherwise regulate—gender transition procedures for minors. Defendants argue that this ban is justified because gender transition procedures "subject vulnerable minors to unproven, harmful, and irreversible procedures." Dkt. 54 at 33. In support, they have designated medical evidence supported by expert reports. *See generally* dkt. 48.

There is thus designated evidence in the record that puberty blockers carry risks of increased brain pressure and reductions in bone density and "may cause hot flashes, weight gain, fatigue and mood alterations." Dkt. 48-4 at 20 (Weiss decl.); dkt. 48-2 at 25 (Hruz decl.). And while puberty blockers are prescribed when puberty starts far too soon, high-quality medical research on

their use to delay puberty past a typical age is exceptionally limited. See dkt. 48-2 at 46 (Hruz decl.); dkt. 48-4 at 21–22 (Weiss decl.). Indeed, the consensus from all sides is that more research is needed to explore these risks. See dkt. 48-4 at 21–23 (Weiss decl.) (identifying statements from healthcare organizations including The Endocrine Society); dkt. 48-1 (Cantor decl.) (summarizing WPATH's calls for further research).

There's also evidence that the cross-sex hormone therapies prohibited by S.E.A. 480 have risks as well. Those include fertility impairment, lower bone density, disfiguring acne, high blood pressure, weight gain, abnormal glucose tolerance, breast cancer, liver disease, thrombosis (blood clots in veins or arteries), and cardiovascular disease. Dkt. 48-2 at 44–46 (Hruz decl.). Hormone therapy is used to treat medical conditions other than gender dysphoria, but—similar to puberty blockers used for gender transition—the "long term effect[s]" of using of cross-sex hormones for gender transition are "currently unknown." *Id.* at 44.

This designated evidence thus provides support for Defendants' view that the safety and effectiveness of puberty blockers and hormone therapy is uncertain and unsettled. It also supports Defendants' position that the State has good reasons for regulating gender transition procedures for minors. Nevertheless, Plaintiffs argue that these "concerns are based on mischaracterizations and distortions about the diagnosis and treatment of gender dysphoria." Dkt. 59 at 2. Maybe Plaintiffs will be able to prove that's true at a trial where Defendants' experts are subject to cross-examination on

the strength of their opinions. *See Lapsley v. Xtek, Inc.*, 689 F.3d 802, 805 (7th Cir. 2012) (explaining that admissible expert evidence "is to be tested . . . with the familiar tools of 'vigorous cross-examination [and] presentation of contrary evidence'"). But based on the paper record available here, the Court finds that Defendants have designated some evidence in support of their position.

Even so, heightened scrutiny requires more—the regulation must have an "exceedingly persuasive justification" and a "close means–end fit." *Sessions*, 582 U.S. at 59, 68. In other words, the State's specific "means" (S.E.A. 480's broad ban) must fit its "ends" (protecting minors and regulating the medical profession). *Sessions*, 582 U.S. at 68; *Virginia*, 518 U.S. at 531 ("Parties who seek to defend gender-based government action must demonstrate an 'exceedingly persuasive justification' *for that action*." (emphasis added)).

So, for example, when the Supreme Court considered the male-only education offered at the Virginia Military Institute, it recognized that sex-based classifications can serve legitimate interests yet not survive heightened scrutiny. *Virginia*, 518 U.S. at 535–36. Therefore, in that case, while "[s]ingle-sex education affords pedagogical benefits to at least some students," and "diversity among public educational institutions can serve the public good," those "benign justifications" were not enough to justify VMI's "categorical exclusions." *Id.*

Here, S.E.A. 480 categorically bans the use of puberty blockers and hormone therapy for gender transition for minors. And Plaintiffs have designated evidence of risks to minors' health and wellbeing from gender

dysphoria if those treatments can no longer be provided to minors—prolonging of their dysphoria, and causing additional distress and health risks, such as depression, posttraumatic stress disorder, and suicidality. See dkt. 26-1 at 16–17 (Karasic decl.).⁴ Those treatments could no longer be used if S.E.A. 480 goes into effect. So, while the State has identified legitimate reasons for regulation in this area, the designated evidence does not demonstrate, at least at this stage, that the extent of its regulation was closely tailored to uphold those interests. Plaintiffs therefore have shown some likelihood of success on the merits of their equal protection claim. See *Mays v. Dart*, 974 F.3d 810, 818 (7th Cir. 2020).

Nor does "the normal rule that courts defer to the judgments of legislatures in areas fraught with medical and scientific uncertainties" settle the issue here. *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2268 (2022). Defendants argue that S.E.A. 480 fits comfortably within this vast zone of legislative discretion, but they have not cited any authority making that

⁴ In their motion to exclude expert testimony, Defendants argue that Dr. Karasic's opinion is unreliable and therefore inadmissible. Dkt. 62; dkt. 63 at 26–27. But Dr. Karasic bases his opinion on his experience "provid[ing] care for thousands of transgender patients," including "patients over the years who were unable to access gender-affirming care when it was clinically indicated." Dkt. 26-1 at 3, 17. That includes minors, "many" of whom then had "increased depression, anxiety, suicidal ideation and self-harm, increased substance use, and a deterioration in school performance." *Id.* at 17. Defendants argue that this experience is "unspecified" and unsupported, dkt. 63 at 26–27, but it is enough to pass *Daubert* gatekeeping. See *Walker v. Soo Line R.R. Co.*, 208 F.3d 581, 586–87 (7th Cir. 2000) (explaining that "experience in treating patients" can qualify a medical expert and "[m]edical professionals reasonably may be expected to rely on self-reported patient histories"). Other than this ruling, Defendant's motion to exclude expert testimony is **DENIED without prejudice** as unnecessary at this stage because this order does not rely on the challenged opinions in concluding that Plaintiffs have carried their preliminary-injunction burden. Dkt. [62].

principle controlling here, when heightened scrutiny applies to an equal protection claim. *See id.* at 2245–46 (*Dobbs* explaining that it did not involve "heightened constitutional scrutiny" but instead "the same standard of review" that applied to "other health and safety measures").

Nevertheless, Defendants argue that "the State has no less restrictive means" than S.E.A. 480 "to advance its interests." Dkt. 54 at 36. They reason that there's "no test for gender dysphoria and no reliable way to know whether it will resolve without lifechanging medical interventions." *Id.*

Defendants don't explain, however, why uncertainty about a gender-dysphoria diagnosis or about how long gender dysphoria may persist leaves the State without more tailored alternatives to S.E.A. 480. At the hearing on Plaintiffs' motion, Defendants emphasized that regardless of any expert testimony, the risks and uncertainties identified in systematic reviews conducted by certain European countries justified S.E.A. 480's ban on gender transition procedures for minors. But reliance on those reviews also does not achieve the "close means–end fit" required.

Most detrimental to Defendants' position is that no European country that has conducted a systematic review responded with a ban on the use of puberty blockers and cross-sex hormone therapy as S.E.A. 480 would. Instead, Defendants' designated evidence is that (1) the English National Health Service has proposed that puberty blockers be used only "in the context of a formal research protocol," (2) Finland's health service has restricted puberty blockers and cross-sex hormone therapies to when gender dysphoria is

severe and other psychiatric symptoms have ceased, (3) the "leading Swedish pediatric gender clinic" has limited puberty blockers and cross-sex hormones to those sixteen and older in monitored clinical trials⁵, (4) the Académie Nationale de Médecine of France has advised providers "to extend as much as possible the psychological support stage" before turning to hormone treatments, and (5) the "Dutch Protocol" developed in the Netherlands involves age restrictions on certain treatments and requires "resolution of mental health issues before any transition." Dkt. 48-1 at 16–21, 110–11 (Cantor decl.).

In short, these European countries all chose less-restrictive means of regulation. In Defendants' view, however, the data from the systematic reviews gives the State unfettered discretion to choose how to regulate gender transition procedures for minors—up to and including a broad prohibition. But that does not take into account the "close means–end fit" that heightened scrutiny requires of sex-based classifications. *Sessions*, 582 U.S. at 59, 68.

Plaintiffs therefore have shown some likelihood of success on their claim that S.E.A. 480's prohibitions on puberty blockers and hormone therapy for minors violate the Equal Protection Clause. *See id.* at 68.

C. First Amendment speech claims

In addition to its treatment prohibitions, S.E.A. 480 prohibits physicians and other medical practitioners from "aid[ing] or abet[ting] another physician or practitioner in the provision of" prohibited gender transition procedures to a

⁵ The Swedish National Board of Health, however, has not imposed those restrictions but "recommends restraint." Dkt. 48-1 at 20.

minor. S.E.A. 480 § 13(b). It's uncontested that § 13(b) would prohibit any action that aids or abets a gender transition procedure. *See* dkt. 54 at 52. It therefore sweeps up both speech—such as medical referrals and discussing a shared patient's care—and conduct—such as driving a minor to receive prohibited care or assisting a surgery. *See id.*

Plaintiffs Dr. Bast and Mosaic therefore challenge this provision as applied to its regulation of speech, arguing that it violates medical providers' First Amendment free speech rights because it prohibits making referrals for or providing information about gender transition procedures. Dkt. 27 at 49; dkt. 59 at 35. Defendants respond that § 13(b) regulates speech only incidentally and is valid as part of a broader regulatory statute. Dkt. 54 at 52–53.

It is "true that the First Amendment does not prevent restrictions directed at commerce or conduct from imposing incidental burdens on speech." *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 567 (2011). But burdens on speech are "incidental" only when they flow indirectly from the core purpose of the regulation—like an employment anti-discrimination ordinance requiring the removal of a "White Applicants Only" sign, or an ordinance against outdoor fires preventing flag burning. *Id.*; *see also Morgan v. White*, 964 F.3d 649, 652 (7th Cir. 2020) (holding that it's an incidental burden on speech when a COVID-related social distancing order makes it harder for a campaign to "round up signatures"). Here, the speech that section 13(b) would prohibit would itself be "aiding and abetting," rather than being incidental to separate, prohibited conduct. *See Expressions Hair Design v. Schneiderman*, 581 U.S.

37, 47 (2017) (holding that a ban on surcharges for using a credit card regulated speech directly rather than incidentally because it dictated how stores communicated prices); *Hurley v. Irish–American Gay, Lesbian and Bisexual Grp. of Boston*, 515 U.S. 557 (1995) (holding that a ban on discrimination based on sexual orientation violated the First Amendment as applied to a parade).⁶

S.E.A. 480 § 13(b) therefore appears to burden speech "on its face and in its practical operation" because "aiding and abetting" directly prohibits referrals and collaboration among medical providers. *Sorrell*, 564 U.S. at 567. Moreover, the regulation triggers heightened scrutiny because it's "directed at certain content and is aimed at particular speakers." *Id.* at 567, 571. Section 13(b) singles out medical providers and only one category of medical treatment—gender transition procedures.

Plaintiffs therefore have some likelihood of success on their First Amendment challenge to S.E.A. 480's aiding and abetting provision, as applied to the speech they have shown to be regulated by that provision. *Cf. Brandt v. Rutledge*, 551 F. Supp. 3d 882, 892 (E.D. Ark. 2021) (finding likelihood of success on a First Amendment challenge to a ban on referrals as part of a similar statute), *aff'd*, 471 F.4th 661, 671–72 (8th Cir. 2022).⁷

⁶ Defendants also argue that S.E.A. 480 § 13(b) is permissible as "an integral part . . . of a valid . . . statute." Dkt. 54 at 52. But for the reasons explained above, Plaintiffs have some likelihood of success on challenges to other portions of S.E.A. 480 as well.

⁷ Because Plaintiffs have shown some likelihood of success for these reasons as to the portions of S.E.A. 480 that they have standing to challenge, the Court does not address Plaintiffs' arguments that S.E.A. 480 (1) denies parents the fundamental right

D. Remaining preliminary injunction factors

1. Irreparable harm

Plaintiffs must also show that they would suffer irreparable harm without an injunction. *See Cassell v. Snyders*, 990 F.3d 539, 545 (7th Cir. 2021). "Harm is irreparable if legal remedies are inadequate to cure it." *Life Spine, Inc. v. Aegis Spine, Inc.*, 8 F.4th 531, 545 (7th Cir. 2021). "Inadequate 'does not mean wholly ineffectual; rather, the remedy must be seriously deficient as compared to the harm suffered.'" *Id.*

Minor Plaintiffs argue that they would suffer irreparable harm if S.E.A. 480 took effect because they would have to stop receiving puberty blockers or hormone therapy to treat the severe condition of gender dysphoria. Dkt. 27 at 52–53. Defendants respond that psychotherapy is available as an alternative treatment. Dkt. 54 at 54–55.

Medical harms, including to mental health, can constitute irreparable harm, *Whitaker v. Kenosha Unified Sch. Dist. No. 1*, 858 F.3d 1034, 1044–46 (7th Cir. 2017), and Defendants do not contest that gender dysphoria is a psychiatric diagnosis that requires "clinically significant distress" to diagnose, dkt. 54 at 14. *Accord Brandt*, 551 F. Supp. 3d at 892 (finding irreparable harm on a similar record), *aff'd*, 471 F.4th at 671–72. And—again—there's evidence that puberty blockers and cross-sex hormone therapy reduces distress for some minors diagnosed with gender dysphoria. *See* dkt. 26-1 at 3, 16–17

to dictate their children's medical care, (2) violates federal Medicaid law, and (3) violates the Affordable Care Act. Dkt. 27 at 33–49.

(Karasic decl.); dkt. 48-12 at 18, 20 (B. Clawson Dep.) (explaining the effects of treatment on K.C.); dkt. 48-14 at 13–14 (Morris Dep.) (same for A.M.); dkt. 48-15 at 19 (R. Welch Dep.) (same for M.W.); dkt. 48-17 at 20 (Rivera Dep.) (same for M.R.). The risk of irreparable harm therefore supports a preliminary injunction. *See Whitaker*, 858 F.3d at 1045 (The irreparable harm requirement does not "require that the harm be certain to occur before a court may grant relief on the merits. Rather, harm is considered irreparable if it cannot be prevented or fully rectified by the final judgment after trial.").

Plaintiffs have also satisfied the irreparable-harm requirement on their First Amendment speech claim. *See Christian Legal Soc'y v. Walker*, 453 F.3d 853, 867 (7th Cir. 2006) ("[V]iolations of First Amendment rights are presumed to constitute irreparable injuries.").

2. Balancing

Because Plaintiffs have some likelihood of success on the merits of constitutional claims, a preliminary injunction is in the public interest. *See Whole Woman's Health All. v. Hill*, 937 F.3d 864, 875 (7th Cir. 2019) ("Enforcing a constitutional right is in the public interest."). While the State has a strong interest in enforcing democratically enacted laws, that interest decreases as Plaintiffs' likelihood of success on the merits of their constitutional claims increases. *See Higher Soc'y of Ind. v. Tippecanoe Cty.*, 858 F.3d 1113, 1116 (7th Cir. 2017). And for the reasons above, Plaintiffs risk suffering irreparable harm absent an injunction. As a result, the balance of harms favors granting a preliminary injunction against the portions of S.E.A. 480 that Plaintiffs have

some likelihood of success in challenging. *See Mays v. Dart*, 974 F.3d 810, 818 (7th Cir. 2020).

3. Bond Requirement

Federal Rule of Civil Procedure 65(c)'s bond requirement is waived. *See BankDirect Cap. Fin., LLC v. Cap. Premium Fin., Inc.*, 912 F.3d 1054, 1058 (7th Cir. 2019). "There is no reason to require a bond" in a case in which "the court is satisfied that there's no danger that the opposing party will incur any damages from the injunction." *Habitat Educ. Ctr. v. U.S. Forest Serv.*, 607 F.3d 453, 458 (7th Cir. 2010). Here, Defendants have not argued a likelihood of money damages or requested a bond. Any party may request an injunction bond while this case remains pending.

E. Scope of the injunction

Plaintiffs are therefore entitled to a partial injunction preventing the enforcement of S.E.A. 480's prohibitions on:

- (1) gender transition procedures, except gender reassignment surgery, S.E.A. 480 § 13(a); and
- (2) "aid[ing] or abet[ting] another physician or practitioner in the provision of" prohibited gender transition procedures to a minor, as applied to speech, *id.* § 13(b). The injunction will run against the regulated speech Plaintiffs have identified—providing patients with information, making referrals to other medical providers, and providing medical records or other information to other medical providers.

Defendants briefly argue that any injunction must be limited to the named plaintiffs. Dkt. 54 at 55–56. They rely on *Doe v. Rokita*, which identified "a problem with the remedy" when a court provides final relief enjoining a statute's application to non-parties without certifying a class action. *Id.* (citing 54 F.4th 518, 519 (7th Cir. 2022)). *Doe*, however, does not apply here because Plaintiffs seek a preliminary injunction while their motion for class certification remains pending. *See* dkt. 10; *Kartman v. State Farm Mut. Auto. Ins. Co.*, 634 F.3d 883, 886 (7th Cir. 2011). Therefore, for the reasons in the Court's order regarding a stay of class-certification briefing, the Court can use its equitable power to issue an injunction prohibiting Defendants from enforcing the enjoined portions of S.E.A. 480 against any provider, as to any minor. *See* dkt. 41 ("[A] court may issue a classwide preliminary injunction in a putative class action suit prior to a ruling on the class certification motion").⁸

⁸ Indeed, briefing on class-certification was stayed at Defendants' request. And Defendants' submissions in support of that request did not mention their view that a stay would later preclude preliminary relief beyond the named plaintiffs. Dkt. 29. Defendants' counsel do not explain why it's appropriate to file such a motion to stay and then raise their view of the scope of available relief for the first time more than a month later in their preliminary-injunction response brief. *See* dkt. 54.

**IV.
Conclusion**

Plaintiffs' motion for a preliminary injunction is **GRANTED in part**. Dkt. [9].⁹ A separate injunction shall issue contemporaneously with this order. See Fed. R. Civ. P. 65(d).

The assigned magistrate judge is asked to enter a case management plan for resolving this case. The Court will then set a trial date.

SO ORDERED.

Date: 6/16/2023



James Patrick Hanlon
United States District Judge
Southern District of Indiana

Distribution:

All electronically registered counsel

⁹ The motion for leave to file brief as *amici curiae* of Arkansas, Alabama, and 14 other states is **GRANTED**. Dkt. [53].

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

JANE DOE 1, et al.,

Plaintiffs,

v.

Case No. 3:23-cv-00230-DJH

WILLIAM C. THORNBURY, JR.,
MD, et al.,

Defendants.

**EXPERT REBUTTAL DECLARATION OF KENNETH W. GOODMAN,
PH.D.**

I, KENNETH GOODMAN, PhD, FACMI, FACE, have been retained by counsel for the Plaintiffs in connection with the above captioned litigation.

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

2. This declaration provides the following expert opinions which are explained in further detail below.

3. Kentucky Senate Bill 150 (“S.B. 150” or “Ban”) prohibits doctors and other health care providers in Kentucky from providing transition medications to minors. This ban will go into effect on June 29, 2023. I understand that health care professionals who violate S.B. 150 will have their licenses revoked and may become subject to civil liability.

4. There is no valid basis for the State to disregard the robust clinical research studies demonstrating the safety and efficacy of gender transition medication, and, in the absence of dispositive evidence demonstrating that such treatments pose significant safety risks and/or lack of efficacy, it is unprecedented for the Board to intrude in the doctor-patient relationship to override the professional judgement of clinicians who adhere to established professional guidelines and standards of care.

5. When parents consent to care for their transgender children, they are consenting to established care supported by the same level and quality of evidence as many other widely accepted treatments for minors.

BACKGROUND AND QUALIFICATIONS

6. I am the founder and director of the University of Miami Miller School of Medicine's Institute for Bioethics and Health Policy and the co-founder and director of the University's Ethics Programs. I also direct the Florida Bioethics Network and chair the UHealth/University of Miami Hospital Ethics Committee as well as the Adult Ethics Committee for Jackson Memorial Health System.

7. I am a full Professor of Medicine with tenure at the University of Miami, with additional appointments in the Department of Philosophy, the Department of Public Health Sciences, and the School of Nursing and Health Studies. My responsibilities include teaching medical ethics to medical students and

trainees and providing continuing education in medical ethics to health professionals at the University of Miami and elsewhere.

8. I received my PhD in Philosophy in 1991 from the University of Miami. I submit this report as an expert in the field of bioethics and the issue of informed consent. A full list of my credentials, experience and publications authored appears in my *curriculum vitae*, which is attached to this report as **Exhibit A**. All institutional affiliations and positions listed here and in my *curriculum vitae* are purely and exclusively for the sake of identification and to demonstrate expertise. The views expressed herein are mine alone.

9. I have extensive experience as a bioethicist. Bioethicists examine the ethical issues that arise in medicine and life sciences. In addition to my research and publication as outlined in my *curriculum vitae*, I am responsible for providing clinical consultative services to providers across the Jackson and University of Miami Health Systems. The purpose of these consultations is to help clinicians make decisions concerning patient care in cases that presents challenging ethical issues.

10. I have actual knowledge of matters stated in this declaration. My expert opinions are based upon my education, training, research, and years of experience as a teacher and medical ethicist, as well as my attendance at and participation in conferences relating to bioethics, and my ongoing review of the relevant professional literature on the subject.

11. In preparing this declaration, I have reviewed the following: the Complaint in this Case; S.B. 150; the expert declarations of Drs. Michael K. Laidlaw, Stephen B. Levine, James M. Cantor, and Geeta Nangia; the Endocrine Society Clinical Practice Guidelines,¹ and the World Professional Association for Transgender Health Standards of Care.² I also relied on my years of research and publication in the field of medical ethics, as set forth in my *curriculum vitae*, and the materials therein.

12. I am not being compensated for offering these opinions, except for the reimbursement of expenses incurred in connection with the submission of this declaration.

13. I previously testified as an expert at trial or by deposition in the following cases: *Adams & Boyle, P.C., et al. v. Herbert H. Slattery, III, et al.*, Case No. 3:15-cv-00705 (M.D. Tenn. 2015), *Gainesville Woman Care, LLC, et al. v. State of Florida, et al.*, Case No. 37 2105 CA 001323 (Circuit Court, Leon County).

¹ Endocrine Society, *Endocrine Treatment of Gender Dysphoric/ Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (September 2017), available at <https://academic.oup.com/jcem/article/102/11/3869/4157558?login=false>.

² World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (8th ver. 2022), available at <https://www.wpath.org/publications/soc>.

**DEFENDANTS’ EXPERTS ERRONEOUSLY ASSERT THAT
THERE IS LITTLE OR NO EVIDENCE FOR THE BENEFITS OF
MEDICAL CARE FOR GENDER DYSPHORIA**

14. The clinical practice guidelines established by the Endocrine Society were developed using the Grading of Recommendations Assessment, Development, and Evaluations (GRADE) guidelines. In this process, guidelines and recommendations are subjected to rigorous internal and external review, including public comment, and undergo peer review prior to publication. Guidelines are reviewed periodically and may be revised and republished based on new evidence.

15. GRADE is a widely accepted framework for developing and presenting summaries of medical evidence and establishing clinical recommendations and guidelines based thereon.³ The framework considers the population in question and the outcomes desired from clinical intervention—here, transgender minor children experiencing gender dysphoria and the alleviation of clinically significant distress associated with such dysphoria. The framework is then used to rank the quality of evidence as applied to the desired outcome to assess the strength of the correlation between the intervention and the desired outcome. The GRADE approach uses four categories to rate the quality of evidence: “high,” “moderate,” “low,” and “very

³ GRADE: Welcome to the GRADE working group; *available at* <https://www.gradeworkinggroup.org/#pub> (last visited June 13, 2023).

low.” These rankings reflect the extent of confidence that the estimates of an effect are adequate to support a particular clinical decision or recommendation.⁴

16. In the rating of evidence, randomized control trials are initially rated as “high quality” and observational studies as “low quality.” A randomized controlled trial (“RCT”) is a study that divides patients randomly into a control group (no treatment) and a treatment group. In contrast, an observational study records information about patients in a real-world setting, *e.g.*, a cohort of patients seen at a clinic. The term “low quality” in this context does not reflect a condemnation of evidence but rather reflects that the body of peer-reviewed literature in this area is comprised of primarily observational studies.

17. The determination of evidence as low quality does not imply the strength of a particular clinical recommendation. In fact, low quality studies regularly guide important aspects of clinical practice, and the GRADE framework specifically notes that GRADE should not be used to dismiss observational studies or to give absolute priority to RCTs, as it appears Defendants’ experts have done here.⁵ Put another way, technically “low quality” evidence can, and often does,

⁴ Howard Balshem, et al., *GRADE guidelines: 3. Rating the quality of evidence*, 64 *J. Clinical Epidemiology* 401, 403 (2011).

⁵ *See, e.g.*, Dkt. 47-9 (Cantor Dec.) at Section III(c) (stating that levels of evidence lower than randomized control trials are unable to establish the effects of a given medical treatment); Dkt. 47-10 (Laidlow Dec.) at ¶76 (describing the use of puberty blockers as “experimental” because “there have been no randomized

support strong clinical recommendations. Further, it is incoherent to suggest that, in the absence of “best-grade” evidence, clinicians should provide no clinical intervention or treatment at all, especially where there is solid evidence that points in the same direction with respect to showing efficacy of treatment. From a practical perspective, if the standard were that clinical practice guidelines could only issue when there was evidence characterized under the GRADE system as “high quality,” many well-established and effective medical treatments would be barred from use. Under current ethical and medical standards, doing so would likely constitute medical malpractice.

18. The WPATH Standards of Care and Endocrine Society Guidelines are parallel to countless other practice guidelines and, indeed, enjoy reliance on a robust and evolving literature. Defendants’ experts misapply the GRADE framework by

controlled trials for this specific use case”), ¶117 (describing the Endocrine Society and WPATH standards as unacceptable substitutes for randomized control trials), ¶¶188, 193 (noting that the Endocrine Society guidelines should not establish the standard of care because they are based on “low quality” evidence, rather than “proper studies”) and ¶ 233 (citing study alleging that the long-term effect of gender transition medication could not be assessed due to a lack of randomized control trials); Dkt. 47-11 (Levine Dec.) at ¶¶132-33 (equating a lack of randomized control trials with a “severe lack of scientific knowledge in this field”) and ¶¶217-18 (asserting that the Endocrine Society guidelines have “serious problems” because the evidence in support of these guidelines are subject to GRADE’s low quality rating); Dkt. 47-12 (Nangia Dec.) at ¶167 (noting that doctors might violate their ethical standards in prescribing gender transition related care due to the “low quality” of the evidence in support of these medical interventions).

dismissing or minimizing the significance of evidence that is “low quality.” This appears a calumny more than a reasoned critique. In addition, while Defendants’ experts purport to rely on standards for evidence-based medicine, they neglect to recognize a key aspect of its foundations: “Evidence-based medicine . . . is the integration of best research evidence with clinical expertise and patient values.”⁶ Leading scholars of evidence-based medicine have long and consistently made clear the essential role of patient values and clinical judgment in evidence-based medical practice. The role of legislatures in regulating that judgment and practice was, until recently, unthinkable. It is and remains, however, scientifically and ethically illicit. In normal circumstances, the measure in question would seem to compel physicians to commit medical neglect or abandonment and, sadly, do so based on ideology and not evidence.

19. In the context of medical treatment for gender dysphoria in minors, the use of an RCT would present serious ethical concerns. The medical care at issue here has been demonstrated, by reliable scientific methods, to be effective in alleviating the distress associated with gender dysphoria and improve mental health outcomes in minors. Given that there is broad medical consensus, based on solid, peer-reviewed research that these medical treatments are safe and effective, it would

⁶ D.L. Sackett, et al., *Evidence-Based Medicine: How to Practice and Teach EBM*. (2d ed. 2000).

likely be unethical to conduct a randomized, placebo-controlled trial, which would entail the withholding of standard treatment from a control group of minors experiencing gender dysphoria.

20. The clinical practice guidelines for treatment of gender dysphoria in minors are consistent with guidelines developed in other areas of pediatric care where many interventions are supported solely or primarily by evidence regarded as less than high quality. Much pediatric practice would be utterly undone and out of bounds if the stance taken by Defendants' experts were applied to many conditions afflicting children. In pediatric oncology, for instance, numerous interventions are both the only options available and are, as such, embraced by the medical community. The same is true in many other specialties; indeed, the lack of RCT evidence has long been a challenge to the pediatrics community (where one analysis found that "43% [of pediatric practice guidelines] were based on experimental studies, 30% on observational studies, and 27% on expert opinion or no reference)."⁷ The GAPSM report would, similarly, enjoin the use of most if not all off-label medication prescriptions. To be sure, observational and case-control studies "may

⁷ Andre Isaac, et al., *Quality of Reporting and Evidence in American Academy of Pediatrics Guidelines*, 131 *Pediatrics* 732–38 (April 2013), available at <https://publications.aap.org/pediatrics/article-abstract/131/4/732/31887/Quality-of-Reportingand-Evidence-in-American?redirectedFrom=fulltext>.

be the only available or practical information in support of a therapeutic strategy.”⁸ Indeed, this is the case with all rare diseases, for which observational and real-world data are all that is available.⁹ It would be medically and ethically impermissible to deny or delay treatment for millions of pediatric patients with a wide range of maladies because a state legislature found fault with the evidentiary bases of available treatments. Similarly, in Kentucky, minors frequently receive cosmetic procedures, including breast augmentation, ear surgery, liposuction, and rhinoplasty – with a less-than-optimal evidence base. These procedures are intended to treat no malady and cure no disease.

21. To my knowledge, the actions of the Kentucky Legislature in prohibiting health care providers from following clinical practice guidelines or standards of care for the treatment of a particular patient population are unprecedented. No other pediatric clinical guidelines or standards of care have been rejected by the Kentucky Legislature because the quality of the evidence supporting them is determined to be less than high quality. Permitting the legislature to bar

⁸ PDQ Adult Treatment Editorial Board, *Levels of Evidence for Adult and Pediatric Cancer Treatment Studies: Health Professional Version*, PDQ Cancer Summaries (Oct. 13, 2022); available at <https://www.ncbi.nlm.nih.gov/books/NBK65748/>.

⁹ Jing Liu, et al., *Natural History and Real-World Data in Rare Diseases: Applications, Limitations, and Future Perspectives*, 62 *J. Clinical Pharmacology* S38-S55 (Dec. 2022), available at <https://accpl.onlinelibrary.wiley.com/doi/10.1002/jcph.2134>.

health care providers from following clinical practice guidelines or standards of care that are based on less than high quality evidence would subject many pediatric patients to serious harm.

22. To be clear, there are no other recommended pediatric clinical guidelines or standards of care subjected to the same degree of scrutiny as the legislature has applied here in an attempt to justify the prohibition on medical treatment for gender dysphoria.

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

Executed on June 15, 2023, in Miami, Florida.



Kenneth W. Goodman, PhD

Exhibit 1

UNIVERSITY OF MIAMI
Curriculum Vitae

1. Date: February 19, 2023

I. PERSONAL

2. Name: Kenneth W. Goodman
3. Phone: (305) 610-2066
4. Office Phone: (305) 243-5723
5. Home Address: 39 Palermo Ave., Coral Gables, FL 33134-6907 USA
6. Current Academic Rank: Professor (as of June 1, 2008; tenure awarded June 1, 2003)
7. Primary Department: Medicine
8. Secondary or Joint Appointments: Philosophy, Public Health Sciences, Health Informatics, Electrical and Computer Engineering, Nursing and Health Studies, Anesthesiology
9. Citizenship: USA
10. Visa Type: NA

II. HIGHER EDUCATION

11. Institutional:
 - Department of Philosophy, University of Miami, Ph.D., 1991 (Dissertation: "Progress and Truth in Science").
 - Department of Language and Linguistics, University of Essex, Colchester, United Kingdom, M.A., 1982. Program in theoretical linguistics; degree conferred with distinction. (Thesis: "Linguistics and Indeterminacy.")
 - Department of Journalism and Communication, University of Florida, B.S., 1975. Degree conferred with high honors.
12. Non-Institutional: NA
13. Certification, licensure: National Incident Management System, Emergency Management Institute, FEMA, "An Introduction," March 10, 2014.

III. EXPERIENCE

14. Academic:

University of Miami Bioethics Program, founder and director, 1991-present. Program redesignated April 2015 as University of Miami Miller School of Medicine Institute for Bioethics and Health Policy

University of Miami Ethics Programs, co-founder and co-director, 1991-present

World Health Organization Collaborating Centre in Ethics and Global Health Policy, director, 2008-present

Faculty Member, Sylvester Comprehensive Cancer Center, 2010-present

Advisory Board, University of Miami Global Health Studies Program, 2019-present

University of Manchester, UK, Civic Data Identity Partnership (CDIP) Advisory Board, 2020-2021

U.S. Centers for Disease Control and Prevention, Ethics Subcommittee of the Advisory Committee to the Director, member, 2011-2013 (committee dissolved May 2013). Public Health Ethics Collaboration Steering Group, member, 2012-2013

Adjunct Professor of Medicine, Florida International University, 2009-2012

Director, Florida Bioethics Network, 2004-present

University of Miami/NIEHS Marine and Freshwater Biomedical Science Center, center investigator, 2001-2003

University of Miami Pan American Bioethics Initiative; founder and director; 1994-present

Member, Course Developers' Group, Comprehensive Institutional Training Initiative (CITI), 2004-2013. Member, CITI Executive Advisory Board, 2006-2012

University of Miami Minority Science Outreach Programs; director; 1994-1998

University of Miami School of Medicine, Department of Medicine; adjunct and joint appointments; 1991-Present

University of Miami College of Arts and Sciences, Department of Philosophy; adjunct and joint appointments; 1991-Present

University of Miami Hospital and Clinics / Sylvester Comprehensive Cancer Center; Director, Clinical and Research Ethics Education; 1995-Present

University of Miami School of Medicine, Division of Minority Affairs, Health Careers Opportunity Program summer faculty, 1999-2003

University of Miami School of Medicine, Division of Minority Affairs, Minority Students Health Careers Motivation Program summer faculty, 2000-2003

Markle Foundation, New York and Washington, D.C., Connecting for Health, Personal Health Technology Council member, 2005-2007

American Society for Bioethics and the Humanities, member, Web Editorial Board, 1998-2001

Barry University, School of Graduate Medical Sciences, Physician Assistant Program, CAAHEP Self Study Advisory Committee, 1998-2000

American College of Epidemiology. As consultant to Ethics and Standards of Practice Committee, developed a "Review and analysis of key documents on ethics and epidemiology," 1993-1994

Carnegie Mellon University, Center for the Advancement of Applied Ethics, Pittsburgh; research associate; 1989-1995

Carnegie Mellon University, Computer Science Department, Center for Machine Translation; research editor; December 1988-August 1991

University of Pittsburgh School of Medicine, Center for Medical Ethics, clinical ethics training program; adjunct faculty and associate; May 1990-July 1991

Duquesne University, Pittsburgh Department of Communication; adjunct faculty; August 1988-May 1991

School of Business and Administration, Duquesne University, Pittsburgh; adjunct faculty; June to July 1991

University of Miami School of Medicine, Health and Human Values Program; adjunct assistant professor; August 1987 to June 1988

University of Miami College of Arts and Sciences, Department of Philosophy; graduate teaching assistant; September 1983-May 1987

Bethune-Cookman College, Daytona Beach, Florida; journalism instructor and student-newspaper adviser, September 1979 to March 1981

15. Hospital Appointments

Founder and chair, University of Miami Hospital Ethics Committee, 2012-present.

Member and Vice Chair, University of Miami Hospital and Clinics / Sylvester Comprehensive Cancer Center Ethics Committee, 1995-2014.

Member, Jackson Memorial Hospital Adult Ethics Committee, 1993-present. Chair as of August 2007.

Member, Jackson Memorial Hospital Pediatric Ethics Committee, 1994-present.

Member, VAMC Miami Ethics Committee, 1994-2003.

16. Non-academic:

Consultant to and educator for various health care organizations and professional organizations, including Nicklaus Children's Hospital, Alpha-1 Foundation, etc.

17. Military: NA

IV. PUBLICATIONS

18: Books and monographs published

Books

1. Goodman KW. *Ethics, Medicine and Information Technology: Intelligent Machines and the Transformation of Health Care*. Cambridge: Cambridge University Press, 2016.
2. de Velasco RE, Fiore RN, Goodman KW, Moseley R, Spike J, Weldon KM, eds. *Guidelines for Ethics Committees: A Resource for Hospitals, Nursing Homes and Hospices*. Miami: The Florida Bioethics Network, 2011.
3. Goodman KW, ed. *The Case of Terri Schiavo: Ethics, Politics and Death in the 21st Century*: Oxford: Oxford University Press, 2010.
4. Goodman KW. *Ethics and Evidence-Based Medicine: Fallibility and Responsibility in Clinical Science*, Cambridge: Cambridge University Press, 2003.
5. Anderson JG, Goodman KW. *Ethics and Informatics: A Case-Study Approach to a Health System in Transition*. New York: Springer Verlag, 2002. Portions adapted as part of "Toward Striking a Balance in Bioinformatics," American Medical Association's online Virtual Mentor, Genethics, March 2001 (<http://virtualmentor.ama-assn.org/2001/03/gnth1-0103.html>).
6. Goodman KW, ed., *Ethics, Computing and Medicine: Informatics and the Transformation of Health Care*. New York and Cambridge: Cambridge University Press, 1998. Translated into Italian by Eugenio Santoro as *Etica, Informatica e Medicina: L'informatica e la trasformazione dell'assistenza sanitaria*, Rome: Il Pensiero Scientifico Editore, 1999. Translated into Japanese by Itai Takashi as 医療IT化と生命倫理 報ネットワーク社会における医療現場の変容, Kyoto: Tankobon, 2009 (ISBN 4790713865, 978-4790713869). See also chapters, below.
7. Coughlin S, Soskolne C, Goodman KW. *Case Studies in Public Health Ethics*. Washington, D.C.: American Public Health Association, 1997. Translated into Mandarin by Xiao Wei as 公共健康伦理学案例研究, Beijing: People's Publishing House 2008 (ISBN 978-7-01-006666-0, R1-05/K584).
8. Goodman KW, Nirenburg S, eds. *The KBMT Project: A Case Study in Knowledge-Based Machine Translation*. San Mateo, Calif: Morgan Kaufmann, 1991.
9. Nirenburg S, Carbonell J, Tomita M, Goodman KW. *Machine Translation: The Knowledge-Based Approach*, San Mateo, Calif.: Morgan Kaufmann, 1991.

Chapters

1. Korngiebel DM, Solomonides A, Goodman KW. Ethical and Policy Issues. In Cohen TA, Patel VL, Shortliffe EH, eds., *Intelligent Systems in Medicine and Health: The Role of AI*. Cognitive Informatics in Biomedicine and Healthcare series. Cham: Springer Nature 2002, pp. 505-525.
2. Goodman KW. Confidentiality and Privacy: Traditional Concerns and Digital Challenges. In Hester DM, Schonfeld TL, eds., *Guidance for Healthcare Ethics Committees*, Second Edition, Cambridge: Cambridge University Press, 2022, pp. 85-94.
3. Goodman KW, Miller RA. Ethics in biomedical and health informatics: Users, standards, and outcomes. In Shortliffe, EH, Cimino JJ, Chiang MF, eds., *Biomedical Informatics: Computer Applications in Health Care and Biomedicine*. Fifth Edition. Cham, Switzerland: Springer Nature, 2021, pp. 391-423. (Revised from the Fourth Edition, 2014, below).

4. Goodman KW, Prineas RJ. Ethics curricula in epidemiology. In SS Coughlin, ed., *Ethics and Epidemiology*, Third Edition, Oxford: Oxford University Press, 2021, pp. 223-244. (Substantially revised version of Goodman and Prineas, 2009).
5. Goodman KW. Bioethics and Precision Medicine: Focus on Information Technology. In Phillips KA, Yamamoto DP, Racz L, eds., *Total Exposure Health: An Introduction*,. Boca Raton: CRC Press, 2020, pp. 281-289
6. Goodman KW, Birnbach DJ. Ethics and plastic surgery practice. In Cohen M, Thaller S, eds., *The Unfavorable Result in Plastic Surgery: Avoidance and Management*, 4th ed., New York: Thieme, 2018, pp. 25-30.
7. Goodman KW. Ethical and legal issues in decision support. In Berner ES, ed., *Clinical Decision Support Systems: Theory and Practice*, Third Edition. Switzerland: Springer International, 2016, pp. 131-146. (Wholly revised from Second Edition, 2007, below.)
8. Goodman KW, Meslin EM. Ethics, information technology and public health: Duties and challenges in computational epidemiology. In Magnuson JA, Fu PC, eds., *Public Health Informatics and Information Systems*, Second Edition, London: Springer-Verlag, 2014, pp. 191-209. (Wholly revised from First Edition, 2003, below.)
9. Goodman KW, Cushman R, Miller RA. Ethics and health informatics: Users, standards, and outcomes. In Shortliffe, EH, et al., eds., *Biomedical Informatics: Computer Applications in Health Care and Biomedicine*. Fourth Edition. New York: Springer, 2014, pp. 329-353. (Wholly revised from the Third Edition, 2006, below).
10. Goodman KW. Ethics and Healthcare: Focus on Information Technology. In McCormick KA, Gugerty B, eds. *Healthcare Information Technology Exam Guide for CompTIA Healthcare IT Technician and HIT Pro Certifications*. New York: McGraw Hill, 2013, 43-59.
11. Goodman KW. Bioética, tecnología de la información y salud. In Herreros Ruiz-Valdepeñas B, Bandrés Moya F, eds. *Bioética: de la globalización a la toma de decisiones*. Madrid: ADEMÁS Comunicación Gráfica, s.l., 2012, 55-60. [Cf. Goodman KW. Bioética e informática de la salud. VI Seminario Internacional e Interuniversitario de Biomedicina y Derechos Humanos, Fundación Tejerina, Madrid, June 24, 2010, below.]
12. Goodman KW. Health information technology and globalization. In Chadwick R, ten Have H, Meslin EM. *Health Care Ethics: Core and Emerging Issues*. Los Angeles: Sage, 2011, 117-125.
13. Ritter IH, Fiore RN, Goodman KW. Justice and vulnerability in human embryonic stem cell research. In H Cheung, ed. *Stem Cell & Regenerative Medicine*. Oak Park, IL: Bentham Scientific Publishers, 2010, pp. 1-8, available at bentham.org/ebooks/9781608050086/contents.htm.
14. Goodman KW. Faculty perspective [on patient confidentiality case]. In Spandorfer J, Pohl CA, Rattner SL, Nasca TJ, eds. *Professionalism in Medicine: A Case-Based Guide for Medical Students*, Cambridge: Cambridge University Press, 2010, 59-60.
15. Goodman KW. Terri Schiavo and the Culture Wars: Ethics vs. Politics. In Goodman KW, ed. *The Case of Terri Schiavo: Ethics, Politics and Death in the 21st Century*: Oxford: Oxford University Press, 2010, 1-38.
16. Goodman KW. Health priorities, conflict of interest and vulnerable populations: how ethics precedes law in the protection of human subjects. In Lolas F, ed., *Dimensiones Éticas de las*

Regulaciones en Salud. Monografías de ACTA BIOETHICA No. 3, Centro Interdisciplinario de Estudios en Bioética, Universidad de Chile Programa de Bioética, OPS/OMS, 2009, 221-232.

17. Goodman KW, Prineas RJ. Ethics curricula in epidemiology. In SS Coughlin, TL Beauchamp and DL Weed, eds., *Ethics and Epidemiology*, Second Edition, Oxford: Oxford University Press, 2009, 283-303. (Substantially revised version of Goodman and Prineas, 1996).
18. Goodman KW. Ethics, evidence and innovation. In Gehner M, Jupp S, Matlin SA, eds. *Global Forum Update on Research for Health Volume 5: Fostering innovation for global health*. Woodbridge, UK: Pro-Brook Publishing, 2008: 88-90. Available at http://globalforumhealth.org/filesupld/global_update5/Update5_FullDoc.pdf
19. Goodman KW. Health information technology: Challenges in ethics, science and uncertainty. In KE Himma and HT Tavani, eds., *The Handbook of Information and Computer Ethics*. Hoboken: Wiley, 2008, pp.: 293-309.
20. Brosco JP, Miller PS, Goodman KW, Fuchs SR. Ethical issues in developmental-behavioral pediatrics: A historical approach. In M.L. Wolraich et al., eds., *Developmental-Behavioral Pediatrics: Evidence and Practice*. Mosby/Elsevier, 2008, pp.: 905-923.
21. Goodman KW. Ethical and legal issues in use of decision support. In E. Berner, ed., *Clinical Decision Support Systems: Theory and Practice*. Second Edition. New York: Springer Verlag, 2007, pp.: 126-139.
22. Goodman KW, Miller RA. Ethics and health informatics: Users, standards, and outcomes. In Shortliffe, E.H., ed., *Biomedical Informatics: Computer Applications in Health Care and Biomedicine*. Third Edition. New York: Springer, 2006, pp. 379-402.
23. Szczepaniak MC, Goodman KW, Wagner MW, Hutman J, Daswani S. Advancing organizational integration: negotiation, data use agreements, law, and ethics. In MW Wagner, AW Moore, RM Aryel, eds. *Handbook of Biosurveillance*. Boston: Academic Press, 2006, pp. 465-480.
24. Goodman KW. Moral foundations of data mining. In Wang J, ed. *Encyclopedia of Data Mining*. Hershey, Penn.: IDEA Group Reference, 2006, pp. 832-836.
25. Borenstein J, Goodman KW. Ethical issues in geriatric psychiatry. In Agronin ME, Maletta GJ, eds., *Principles and Practice of Geriatric Psychiatry*. Philadelphia: Lippincott, 2006, 259-269.
26. Goodman KW. Ethics, information technology and public health: Duties and challenges in computational epidemiology. In O'Carroll PW, Yasnoff WA, Ward ME, Ripp LH and Martin EL, eds., *Public Health Informatics and Information Systems*, New York: Springer-Verlag, 2003, 251-266.
27. Goodman KW. Justifying embargoes: The "Ethics Criterion." In R Vázquez Díaz, ed., *Health and Nutrition in Cuba: Effects of the U.S. Embargo*. Stockholm: Olof Palme International Center, 1998.
28. Goodman KW. Ethical challenges. In J.A. Herzstein, W.B. Bunn, L.E. Fleming et al., eds. *International Occupational and Environmental Medicine*. St. Louis: Mosby, 1998: 86-96.
29. Goodman KW. Outcomes, futility, and health policy research. In K.W. Goodman, ed., *Ethics, Computing and Medicine: Informatics and the Transformation of Health Care*, Cambridge and New York: Cambridge University Press, 1998: 116-138.

30. Goodman KW. Meta-analysis: Conceptual, ethical and policy issues. In K.W. Goodman, ed., *Ethics, Computing and Medicine: Informatics and the Transformation of Health Care*, Cambridge and New York: Cambridge University Press, 1998: 139-167.
31. Goodman KW. Bioethics and Health Informatics: An Introduction. In KW Goodman, ed., *Ethics, Computing and Medicine: Informatics and the Transformation of Health Care*, Cambridge and New York: Cambridge University Press, 1998: 1-31. (Adapted and reprinted with accompanying commentary as Bioethics and health informatics, *Biomedical Ethics*, newsletter of the European Network for Biomedical Ethics 1999;4(2):40-43.)
32. Miller R., Goodman KW. Ethical challenges in the use of decision-support software in clinical practice. In KW Goodman, ed., *Ethics, Computing and Medicine: Informatics and the Transformation of Health Care*. Cambridge and New York: Cambridge University Press, 1998: 102-115.
33. Goodman KW, Frumkin H. Ethical issues in international occupational health, in LE Fleming et al., eds., *International Occupational and Environmental Medicine*, Beverly, Mass.: OEM Press, 1997, 17-32.
34. Goodman KW, Prineas, R. Toward an ethics curriculum in epidemiology, in S. Coughlin and T. Beauchamp, eds., *Ethics and Epidemiology*, Oxford University Press, 1996, 290-303.
35. Goodman KW. Anticipations of truth: historical evidence for a realist account of scientific progress. In D. Prawitz and D. Westerståhl, eds., *Logic and Philosophy of Science in Uppsala*, Dordrecht: Kluwer (now, Springer/Synthese), 1994, 273-295.

19. Juried or refereed journal articles or exhibitions

1. Ross SR, Goodman KW. Avoiding Unethical Altruism in Global Health: Revisiting Ethics Guidelines for International Rotations for Medical Residents. *Journal of Graduate Medical Education* 2023;15(1):19-23. <https://doi.org/10.4300/JGME-D-22-00455.1>
2. Salerno J, Coughlin SS, Goodman KW, Hlaing WM. Current ethical and social issues in epidemiology. *Annals of Epidemiology* 2023;50:37-42. <https://doi.org/10.1016/j.annepidem.2023.02.001>
3. Petersen C, Berner ES, Cardillo A, Fultz Hollis K, Goodman KW, Koppel R, Korngiebel DM, Lehmann CU, Solomonides AE, Subbian V. AMIA's code of professional and ethical conduct 2022, *Journal of the American Medical Informatics Association* 2023;30(1):3-7. <https://doi.org/10.1093/jamia/ocac192>
4. Lehmann CU, Fultz Hollis K, Petersen C, DeMuro PR, Subbian V, Koppel R, Solomonides AE, Berner ES, Pan EC, Adler-Milstein J, Goodman KW. Selecting venues for AMIA events and conferences: guiding ethical principles. *Journal of the American Medical Informatics Association* 2022;29(8): 1319–1322, <https://doi.org/10.1093/jamia/ocac073>
5. Dimentstein K, Sosenko JM, Goodman KW. Do-it-yourself diabetes management: perspectives of a patient, a physician, and an ethicist. *Clinical Diabetes* 2021 Aug; cd200058. <https://doi.org/10.2337/cd20-0058>.
6. Hlaing WM, Kushch NA, Wells AE, Goodman KW. Common topics discerned in ethics in epidemiology and public health syllabi: in-depth review. *Annals of Epidemiology* 2021;60:31-34. <https://doi.org/10.1016/j.annepidem.2021.04.014>

7. Brodar C, Muller C, Brodar KE, Brosco JP, Goodman KW. Ethics Education in COVID-19: Preclinical Medical Students' Approach to Ventilator Allocation. *Cureus* 2021;13(8): e16976. doi:10.7759/cureus.16976
8. Gershengorn HB, Holt GE, Rezk A, Delgado S, Shah N, Arora A, Colucci LB, Mora B, Iyengar RS, Lopez A, Martinez BM, West J, Goodman KW, Kett DH, Brosco JP. Assessment of Disparities Associated With a Crisis Standards of Care Resource Allocation Algorithm for Patients in 2 US Hospitals During the COVID-19 Pandemic. *JAMA Network Open* 2021;4(3):e214149. doi:10.1001/jamanetworkopen.2021.4149
9. Petersen C, Smith J, Freimuth RR, Goodman KW, Jackson GP, Kannry J, Liu H, Madhavan S, Madhavan S, Sittig DF, Wright A. Recommendations for the safe, effective use of adaptive CDS in the US healthcare system: an AMIA position paper, *Journal of the American Medical Informatics Association* 2021 *Journal of the American Medical Informatics Association* 2021;28(4):677–684. <https://doi.org/10.1093/jamia/ocaa319>
10. Golembiewski EH, Mainous AG, Rahmanian K, Brumback B, Rooks BJ, Krieger JL, Goodman KW, Moseley RE, Harle CA. An electronic tool to support patient-centered broad consent: A multi-arm randomized clinical trial in family medicine. *Annals of Family Medicine*. 2021;19(1):16-23. <https://doi.org/10.1370/afm.2610>
11. Subbian V, Solomonides A, Clarkson M, Rahimzadeh VN, Petersen C, Schreiber R, DeMuro PR, Dua P, Goodman KW, Kaplan B, Koppel R, Lehmann CU, Pan E, Senathirajah Y. Ethics and Informatics in the Age of COVID-19: Challenges and Recommendations for Public Health Organization and Public Policy. *Journal of the American Medical Informatics Association*. 2021;28(1):184-189. doi: 10.1093/jamia/ocaa188
12. Goodman KW, Zandi D, Reis A, Vayena E. Balancing risks and benefits of artificial intelligence in the health sector. *Bulletin of the World Health Organization* 2020;98:230-230A. doi: <http://dx.doi.org/10.2471/BLT.20.253823>
13. Rubinstein PF, Middleton B, Goodman KW, Lehmann CU. Commercial interests in continuing medical education: Where do electronic health records fit? *Academic Medicine* 2020;95(11):1674-1678. doi: 10.1097/ACM.0000000000003190. PMID: 32079950.
14. Walsh CG, Chaudhry B, Dua P, Goodman KW, Kaplan B, Kavuluru R, Solomonides A, Subbian V. Stigma, biomarkers, and algorithmic bias: recommendations for precision behavioral health with artificial intelligence. *JAMIA Open* 2020;3(1):9-15. doi: 10.1093/jamiaopen/ooz054
15. Goodman KW. Ethics and health informatics. *International Yearbook of Medical Informatics*. 2020:26-31. <http://dx.doi.org/10.1055/s-0040-1701966>
16. Civantos FJ, Leibowitz JM, Arnold DL, Stubbs VC, Gross JH, Thomas GR, Sargi Z, Casiano RR, Franzmann EJ, Weed D, Perez C, Samuels M, Goodman KW, Goodwin WJ. Ethical surgical triage of patients with head and neck cancer during the COVID-19 pandemic. *Head & Neck* 2020;42:1423-1447, <https://doi.org/10.1002/hed.26229>
17. Kareff SA, McNulty M, Goodman KW, Agarwal G. Introducing first-year dual-degree medicine and public health students to ethics and professionalism. *Journal of Hospital Ethics* 2019;6(2):95-100.
18. Hlaing WM, Saddemi JL, Goodman KW. Expanding ethics curriculum resources: American College of Epidemiology's syllabus collection project. *Annals of Epidemiology* 2019;38:1-3; doi: [doi: doi.org/10.1016/j.annepidem.2019.08.009](https://doi.org/10.1016/j.annepidem.2019.08.009)

19. Harle CA, Golembiewski EH, Rahmanian KP, Brumback B, Krieger JL, Goodman KW, Mainous AG, Moseley RE. Does an interactive trust-enhanced electronic consent improve patient experiences when asked to share their health records for research? A randomized trial. *Journal of the American Medical Informatics Association* 2019;26(7):620-629. doi.org/10.1093/jamia/ocz015.
20. Miklin DJ, Vangara SS, Delamater AM, Goodman KW. Understanding of and barriers to electronic health records in a culturally diverse pediatric population. *JMIR Medical Informatics* 2019;7(2):e11570. doi:10.2196/11570
21. Lehmann CU, Petersen C, Bhatia H, Berner ES, Goodman KW. Advance directives and code status information exchange: a consensus proposal for a minimum set of attributes. *Cambridge Quarterly of Healthcare Ethics* 2019;28(1):178-185. doi.org/10.1017/S096318011800052X. PMID:30570474
22. Holt GE, Goodman KW, Olvey SE, Kett D. Nonstandard do-not-resuscitate orders. *Current Opinions in Anaesthesiology* 2018 Dec 6. doi: 10.1097/ACO.0000000000000690. [Epub ahead of print] PMID: 30531615.
23. Wo SR, Largent EA, Brosco J, Rosenberg AR, Goodman KW, Lantos JD. Should Foreigners Get Costly Lifesaving Treatments in the United States? *Pediatrics* 2018;142(5). pii: e20180175. doi: 10.1542/peds.2018-0175. PMID: 30279236.
24. Perry JD, Parrish RK, Goodman KW. The prospective retrospective study. *American Journal of Ophthalmology* 2018;196:xiii-xv. https://doi.org/10.1016/j.ajo.2018.09.006.
25. Malin B, Goodman KW. Between access and privacy: Challenges in sharing health data. International Medical Informatics Association, *IMIA Yearbook of Medical Informatics* 2018;27:55-59. Doi: dx.doi.org/10.1055/s-0038-1641216 [https://www.thieme-connect.com/products/ejournals/journal/10.1055/s-00034612]
26. Petersen C, Berner ES, Embi PJ, Fultz Hollis K, Goodman KW, Koppel R, Lehmann CU, Lehmann H, Maulden SA, McGregor KA, Solomonides A, Subbian V, Terrazas E, Winkelstein P. AMIA's code of professional and ethical conduct. *Journal of the American Medical Informatics Association* 2018;25(11):1579–1582. doi.org/10.1093/jamia/ocy092.
27. Buttrick SS, Cajigas I, Achua JK, O'Phelan K, Goodman KW, Benveniste RJ. Prospective study of nonbeneficial care in neurocritical care unit. *World Neurosurgery* 2018;119: e60-e63. doi: 10.1016/j.wneu.2018.06.240. PMID: 29981912
28. Salerno J, Knoppers BM, Lee LM, Hlaing WM, Goodman KW. Ethics, big data and computing in epidemiology and public health. *Annals of Epidemiology* 2017;27:297-301. doi: 10.1016/j.annepidem.2017.05.002. PMID: 28595734.
29. Goodman KW. Health information technology as a universal donor to bioethics education. *Cambridge Quarterly of Healthcare Ethics* 2017;26(2):342-347. doi: 10.1017/S0963180116000943. PMID: 28361731.
30. Tenenbaum JD, Goodman KW. Beyond the Genetic Information Nondiscrimination Act: ethical and economic implications of the exclusion of disability, long-term care and life insurance. *Personalized Medicine* 2017;14(2):153-157. doi: 10.2217/pme-2016-0078.
31. Sandhaus RA, Turino G, Brantly ML, Campos M, Cross CE, Goodman K, Hogarth DK, Knight SL, Stocks JM, Stoller JK, Strange C, Techman J. The diagnosis and management of alpha-1

antitrypsin deficiency in the adult. *Chronic Obstructive Pulmonary Diseases* 2016; 3(3): 668-682. doi: <http://dx.doi.org/10.15326/jcopdf.3.3.2015.0182>.

32. Fiore RN, Goodman KW. Precision medicine ethics: selected issues and developments in next-generation sequencing, clinical oncology, and ethics. *Current Opinions in Oncology* 2016 Jan;28(1):83-7. doi: 10.1097/CCO.0000000000000247. PubMed PMID: 26569425.
33. Coors M, Bauer L, Edwards K, Erickson K, Goldenberg A, Goodale J, Goodman K, Grady C, Mannino D, Wanner A, Wilson T, Yarborough M, Zirkle M. Ethical issues related to clinical research and rare diseases: 15th Gordon L. Snider Critical Issues Workshop, April 1, 2016, Bethesda, Maryland. *Translational Science of Rare Diseases* 2017;2(3-4):175-194. doi: 10.3233/TRD-170013
34. Litewka S, Goodman KW. Paediatric research in Latin America: Focus on governance and populations. *Asian Bioethics Review* 2015;7(2):179-187.
35. Ownby RL, Acevedo A, Goodman KW, Caballero J, Waldrop-Valverde D. Health literacy predicts participant understanding of orally-presented informed consent information. *Clinical Research and Trials* 2015;1(1)15-19. doi: 10.15761/CRT:1000105. PMCID: PMC4709021. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4709021/>.
36. Dhiman GJ, Amber KT, Goodman KW. Comparative outcome studies of clinical decision support software: limitations to the practice of evidence-based system acquisition. *Journal of the American Medical Informatics Association* 2015 Apr;22(e1):e13-20. doi: 10.1093/jamia/ocu033. PMID: 25665704.
37. Goodman KW. Informatics, biomedical. In Jennings, B., ed., *Bioethics*, 4th Edition. Farmington Hills, MI: Macmillan Reference USA, 2014, Vol. 3, pp. 1661-1665.
38. Saenz C, Heitman E, Luna F, Litewka S, Goodman KW, Macklin R. Twelve years of Fogarty-funded bioethics training in Latin America and the Caribbean: Achievements and challenges. *Journal of Empirical Research on Human Research Ethics* 2014;9(2):80-91. doi: 10.1525/jer.2014.9.2.80. PMID: 24782074
39. Amber KT, Dhiman G, Goodman KW. Conflict of interest in online point-of-care clinical support websites. *Journal of Medical Ethics* 2014;40(8):578-80. doi: 10.1136/medethics-2013-101625, PMID: 24493079.
40. Fix J, Odell J, Sina B, Meslin EM, Goodman KW, Upshur R. A bibliometric analysis of an international research ethics trainee program. *Journal of Empirical Research on Human Research Ethics* 2013;8(5):75-81. doi: 10.1525/jer.2013.8.5.75. PMID: 24384518
41. Petersen C, Demuro P, Goodman KW, Kaplan B. Sorrell v. IMS Health: issues and opportunities for informaticians. *Journal of the American Medical Informatics Association* 2013;20(1):35-37. doi:10.1136/amiainl-2012-001123 35. PMID: 23104048
42. Goodman KW, Adams S, Berner ES, Embi PJ, Hsiung R, Hurdle J, Jones DA, Lehmann CU, Maulden S, Petersen C, Terrazas E, Winkelstein P. AMIA's Code of Professional and Ethical Conduct. *Journal of the American Medical Informatics Association* 2013;20:141-143. doi:10.1136/amiainl-2012-001035. PMID: 22733977
43. Myerburg RJ, Goodman KW, Ringe TBK. Electronic control devices: Science, law and social responsibility. *Circulation* 2012;125:2406-2408. doi: 10.1161/CIRCULATIONAHA.112.107359. PMID: 22547670

44. Massoudi BL, Goodman KW, Gotham IJ, Holmes JH, Lang L, Miner K, Potenziani DD, Richards J, Turner AM, Fu PC. An informatics agenda for public health: summarized recommendations from the 2011 AMIA PHI Conference. *Journal of the American Medical Informatics Association* 2012;9(5):688-695. doi: 10.1136/amiajnl-2011-000507. Epub 2012 Mar 6. PMID: 22395299
45. McCafferty J, Cushman R, Goodman KW, Braunschweiger P, Fiore RN. New NSF and NIH responsible conduct of research (RCR) guidelines: A three-phase plan. *Teaching Ethics* 2012;12(2):23-33.
46. Goodman KW, Berner ES, Dente MA, Kaplan B, Koppel R, Rucker D, Sands DZ, Winkelstein P. Challenges in ethics, safety, best practices, and oversight regarding HIT vendors, their customers, and patients: a report of an AMIA special task force. *Journal of the American Medical Informatics Association* 2011;18(1):77-81. doi: 10.1136/jamia.2010.008946. PMID: 21075789.
47. Cushman R, Fromkin AM, Cava A, Abril P, Goodman KW. Ethical, legal and social issues for personal health records and applications. *Journal of Biomedical Informatics* 2010;43:S51-S55, doi:10.1016/j.jbi.2010.05.003. PMID: 20937485
48. Goodman KW. Ethics, information technology and public health: New challenges for the clinician-patient relationship, *Journal of Law, Medicine and Ethics* 2010;38(1):58-63. doi: 10.1111/j.1748-720X.2010.00466.x. PMID: 20446984
49. Goodman KW. Comment on M.R. Tonelli, "The challenge of evidence in clinical medicine." *Journal of Evaluation in Clinical Practice* 2010;16(2):390-1. PMID: 2036787
50. Rosenfeld PJ, Goodman KW. When is off-label drug use in the patient's best interest? *American Journal of Ophthalmology* 2009; 147:761-763 (editorial). PMID: 19376327
51. Goodman KW. Publication and authorship. CITI. <https://www.citiprogram.org/>, 2009-2014.
52. Goodman KW, Cava A. Bioethics, business ethics, and science: Bioinformatics and the future of healthcare. *Cambridge Quarterly of Healthcare Ethics* 2008;17(4):361-372. PMID: 18724877
53. Litewka S, Goodman KW, Braunschweiger P. El Programa CITI: Una alternativa para la capacitación en ética de la investigación en América Latina. *Acta Bioethica* 2008;14(1):54-60.
54. Koniaris LG, Goodman KW, Sugarman J, Ozomaro U, Sheldon J, Zimmers TA. Ethical implications of modifying lethal injection protocols. *PLoS Medicine*, 2008; 5 (6): e126 DOI: 10.1371/journal.pmed.0050126. PMID:18547139
55. Mitchell CD, Armstrong FD, Goodman KW, Cava A. Disclosure of HIV status to an infected child: Medical, psychological, ethical, and legal perspectives in an era of "super-vertical" transmission. *The Journal of Clinical Ethics* 2008;10(1):43-52. PMID: 18552052
56. Brackett NL, Lynne CM, Attia GR, Carmack AJK, Cava A, Goodman KW. Treatment of infertility in men with spinal cord injury: Medical progress and ethical considerations. *Topics in Spinal Cord Injury Rehabilitation* 2008;13(4):120-133.
57. Goodman KW. Privacy, confidentiality, law and ethics. *Northeast Florida Medicine Supplement* 2008;January:28-30.

58. Goodman KW. Bioethics resources in Florida. *Northeast Florida Medicine Supplement* 2008;January: 37-38.
59. Glasser DJ, Goodman KW, Einspruch NG. Chips, tags and scanners: Ethical challenges for radio frequency identification. *Ethics and Information Technology* 2007;9:101-109.
60. Braunschweiger P, Goodman KW. The CITI Program: An international online resource for education in human subjects protection and the responsible conduct of research. *Academic Medicine* 2007;82:861-864. PMID: 17726392
61. Winick BJ, Goodman KW. A therapeutic jurisprudence perspective on participation in research by subjects with reduced capacity to consent: A comment on Kim and Appelbaum. *Behavioral Sciences and the Law* 2006;24:485-494. PMID: 16883619
62. Goodman KW. Ethics, evidence, and public policy. *Perspectives in Biology and Medicine* 2005;48(4):548-556. PMID:16227666
63. Goodman KW. Ethics and health informatics: Focus on Latin America and the Caribbean. *Acta Bioethica* 2005;11(2):121-126. [In special issue, "Technologías de la Información," edited by KW Goodman.]
64. Berner ES, Sandhu AS, Goodman KW. Consumer health informatics: Ethics, evaluation and standards. *Acta Bioethica* 2005;11(2):133-144. [In special issue, "Technologías de la Información," edited by KW Goodman.]
65. Goodman KW. Clinical Case. Confusion Over Cholesterol Testing. Commentary 1. *Virtual Mentor*, American Medical Association, December 2004. Available at <http://virtualmentor.ama-assn.org/2004/12/ccas2-0412.html>
66. Lewin LO, Olson CA, Goodman KW, Kokotailo PK. UME-21 and teaching ethics: A step in the right direction. *Family Medicine* 2004;36 (January suppl.): 36-42. PMID:14961401
67. Brito A, Sosenko J, Goodman KW. Unusually difficult challenges in human-subjects research. *Professional Ethics* 2003;11(3): 39-43. PMID: 15468490
68. Goodman KW. Genetic research in human populations. CITI course in the protection of human research subjects. <https://www.citiprogram.org/>, 2003-2015.
69. Cava A, Cushman R, Goodman KW. HIPAA and human subjects research. CITI course in the protection of human research subjects. <https://www.citiprogram.org/>, 2003-2008.
70. Yasnoff WA, Overhage JM, Humphreys BL, LaVenture M, Goodman KW, Gatewood L, Ross DA, Reid J, Hammond WE, Dwyer D, Huff SM, Gotham I, Kukafka R, Loonsk JW, Wagner MM. A national agenda for public health informatics. *Journal of Public Health Management Practice* 2001;7:1-21.
71. Goodman KW. Persistent legislative state: Law, education, and the well-intentioned healthcare ethics committee. *Healthcare Ethics Committee Forum* 2001;13:32-40.
72. Nelson W, Angoff N, Binder E, Cooke M, Fleetwood J, Goodlin S, Goodman KW, et al. Goals and strategies for teaching death and dying in medical schools. *Journal of Palliative Medicine* 2000;3:7-16.
73. Thurman A, McCrudden P, Hamric AB, Goodman KW. The illegal alien who needs surgery. *Cambridge Quarterly of Healthcare Ethics* 2000;9(1):128-135.

74. Goodman KW. Philosophy as news: Bioethics, journalism and public policy. *Journal of Medicine and Philosophy* 1999;24:181-200.
75. Markovitz BP, Goodman KW. Case reports on the Web: Is confidentiality being maintained? In Lorenzi NM, ed., *Proceedings of the Annual Symposium of the American Medical Informatics Association*, Philadelphia: Hanley & Belfus, 1999, p. 1114.
76. Goodman, KW. End-of-life algorithms. *Journal of Psychology, Public Policy and Law* 1998;4:719-727. PMID: 12803230
77. Prineas RJ, Goodman KW, Soskolne CL et al. Findings from the American College of Epidemiology's survey on ethics guidelines. *Annals of Epidemiology* 1998;8:482-489.
78. Goodman KW. Electronic health data and the challenges of medical confidentiality. *Journal of the Florida Medical Association* 1997;84:494-7.
79. Goodman KW. Ethics, genomics, and information retrieval. *Computers in Biology and Medicine* 1996;26:223-229. PMID: 8725773
80. Goodman KW. Codes of ethics in occupational and environmental health. *Journal of Occupational and Environmental Medicine* 1996;38:882-883.
81. Balkany T, Hodges AV, Goodman KW. Ethics of cochlear implantation in young children, *Otolaryngology—Head and Neck Surgery* 1996;114:748-755. Revised as "Cochlear implants for young children: Ethical issues," Chap. 2, in W. Estabrooks, ed., *Cochlear Implants for Kids*, Washington, D.C.: Alexander Graham Bell Association for the Deaf, 1998, pp. 30-44.
82. Goodman KW. Critical care computing: outcomes, confidentiality and appropriate use. *Critical Care Clinics* 12;1996:109-122.
83. Goodman KW. Intellectual property and control. *Academic Medicine* 1993;68.9:S88-S91.
84. Goodman KW. Electronic roundtables for medical ethics. *Kennedy Institute of Ethics Journal* 1992;2:233-251.
85. Nirenburg S, Goodman KW. Treatment of Meaning in MT Systems, *Proceedings of the Third International Conference on Theoretical and Methodological Issues in Machine Translation of Natural Languages*, University of Texas at Austin, 1990:171-188.
86. Goodman KW. Psychoanalytic interpretations, in Weingartner P, Schurz G, eds. *Recent Developments in Epistemology and Philosophy of Science: Reports of the 11th International Wittgenstein-Symposium*. Vienna: Hölder-Pichler-Tempsky, 1987:280-287.

20. Other works, publications and abstracts:

1. Various contributors. Ethics and governance of artificial intelligence for health. World Health Organization, 2021, <https://www.who.int/publications/i/item/9789240029200>.
2. Cañete R, Goodman KW. Cuba-US collaboration: The pandemic imperative. *MEDICC Review* 2021;23(1):89. <https://doi.org/10.37757/MR2021.V23.N1.3>

3. Zandi D, Reis A, Vayena E, Goodman K. New ethical challenges of digital technologies, machine learning and artificial intelligence in public health: a call for papers. *Bulletin of the World Health Organization* 2019;97:2.
4. Goodman KW. Expert perspective (on “No DNR tattoo for me, thanks”). *Caring for the Ages* 2018;19:12. DOI: 10.1016/j.carage.2018.12.005.
5. Holt GE, Sarmiento B, Kett D, Goodman KW. An Unconscious Patient with a DNR Tattoo. *New England Journal of Medicine* 2017;377:2192-2193. doi: 10.1056/NEJMc1713344. PMID: 29171810.
6. Holt GE, Kett D, Goodman KW. More on an Unconscious Patient with a DNR Tattoo. *New England Journal of Medicine* 2018; 378:875-877. doi: 10.1056/NEJMc1800052. PMID: 29490184.
7. Fairchild A, Agoudavi K, Amzat J, Bayer R, Calain P, Cong Y, Dawson A, Gayrel C, Gibson JL, Goodman KW, Gopichandran V, Haghdoost AA, Heldal E, Ho C, Jafri H, Lee LM, Litewka S, Mobasher M, Moodley K, Okyere B, Consorcia Quizon M, Reis A, Sawanpany-alert P, Selgelid M, Upshur R, Vayena E. *WHO Guidelines on Ethical Issues in Public Health Surveillance*. Geneva: World Health Organization, 2017.
8. Miklin DJ, Vangara SS, Goodman KW. Understanding of and barriers to electronic health records in a culturally diverse pediatric population. 4th Annual Pediatric Student Research Forum, Orlando, September 15, 2017.
9. Kareff S, Goodman K. Ethics in MD/MPH curricula: A case study describing unique considerations for dual-degree students. *MedEdPublish* 2017; 6(2): 2. DOI:<https://doi.org/10.15694/mep.2017.000064>
10. Goodman KW. Introduction: Symposium on ethical issues in data science and digital medicine. *Cambridge Quarterly of Healthcare Ethics* 2017;26(2):326-327. DOI: <https://doi.org/10.1017/S0963180116000906>.
11. Buttrick S, O’Phelan K, Goodman K, Benveniste RJ. Prospective study of futile care in the neuroscience intensive care unit. Congress of Neurological Surgeons, www.neurosurgery-online.com 2016;63:174.
12. Goodman KW. Addressing ethical issues in health information technology. Guest Editorial. *Cambridge Quarterly of Healthcare Ethics* 2015;24:252-4.
13. Cañete R, Goodman KW. Cuba-US collaboration and the role of bioethics. Letter. *The Lancet* 2015;385 (9972):945.
14. Goodman KW. Health analytics and big data. *Lahey Health Journal of Medical Ethics* 2014;Spring:9-10.
15. Bishop EM, Mandel NS, Brosco JP, Goodman KW, Mechaber AJ, Mechaber HF. Third-Year Medical Student Debrief Groups: Maintaining Empathy in the Clinical Years. Poster, AAMC Group on Student Affairs/Group on Diversity Affairs/Organization of Student Representatives National Meeting, San Diego, April 2014.
16. Goodman KW. Review of *Handbook of Analytic Philosophy of Medicine*, Sadegh-Zadeh, K., Dordrecht: Springer, 2012. *Journal of Biomedical Informatics* 2013;46:782-783, DOI 10.1016/j.jbi.2013.06.005.

17. Goodman KW. Getting it Goldilocks just right: Science, regulation and ethics. *Cell* 2013;1(2):154-155/e387.
18. Landy DC, Goodman KW, Brosco JP. Clinical ethics and patient satisfaction: The practical significance of distinguishing ethics and morals. *The American Journal of Bioethics* 2012;12(5):20-22. doi: 10.1080/15265161.2012.671888. PMID: 22548518
19. Goodman KW. What would you do? Test yourself on this ethical dilemma. MedScape, Aug. 8, 2012. Available at <http://www.medscape.com/viewarticle/768554>.
20. Green JBA, Bernstein J, Green RM, Goodman KW, Paris J, Tauer C. European stem-cell ruling is misleading (letter). *Nature* 2011;479:41.
21. Nissan J, Beckerman S, Paoloemilio J, Jenkins J, Dunn A, Ashbaugh H, Mechaber A, Goodman K, Sanders L, Brosco J. Project SERVE: A community-based approach to social medicine education. Referred abstract, American Association of Medical Colleges and Organization of Student Representatives Annual Meeting, Washington, D.C., November 2010.
22. Sylvester M, Goodman KW. Patient Confidentiality 2," in Spandorfer J et al., eds. *Professionalism in Medicine*, Cambridge University Press (2010) pp. 57-60.
23. Meslin EM, Goodman KW. Bank on it: An ethics and policy agenda for biobanks and electronic health records. Center for American Progress, Science Progress, Feb. 25, 2010, http://scienceprogress.org/2010/02/bank-on-it/#_edn25.
24. Esposito K, Goodman K. Genethics 2.0: Phenotypes, genotypes, and the challenge of databases generated by personal genome testing. *The American Journal of Bioethics* 2009;9(6):19-21. PMID: 19998105
25. Cohen DA, Goodman KW, Andrews D. Ethical and educational challenges in reporting clinical significance of a multi-disease gene as illustrated by the methylene tetrahydrofolate reductase (Mthfr) C677t polymorphism (abstract). National Coalition for Health Professional Education in Genetics, annual meeting, Bethesda, September 22, 2009.
26. Goodman KW, Einspruch NG. The way forward in the world of robotics (letter). *Science* 24 April 2009 324: 463-464. [DOI: 10.1126/science.324_463d]. PMID: 19390022 (Reprinted in Kennedy ML, Kennedy WJ, eds. *Writing in the Disciplines: A Reader and Rhetoric for Academic Writers*. Boston: Pearson, 2012: 361-362.)
27. Goodman KW, Fiore RN. Toward a research ethics consultation service. *American Journal of Bioethics* 2008;8(3):31-32. PMID: 18570098.
28. Goodman KW. Privacy as an international value. *Minas faz Ciência* 2008 (November): 32-33. (Published by the Fundação de Amparo à Pesquisa do Estado de Minas Gerais [Foundation for the Support of Research in the State of Minas Gerais (Brazil)].)
29. Goodman KW. On the growth of ethics programs. In Schrag B, ed. *Developing Relationships: How Ethics Center Can Succeed with Raising Funds*. Adapted papers from an Ethics Center Colloquium, Annual Meeting of the Association for Practical and Professional Ethics, San Antonio, Feb. 21, 2008. APPE: Bloomington, Ind., 2008, pp. 11-13.
30. Goodman KW. Ethics, schmethics: The Schiavo case and the culture wars. *University of Miami Law Review* 61:2007:863-865.

31. Marckmann G, Goodman KW. Introduction: Ethics of Information Technology in Health Care. *International Review of Information Ethics (ERIE)* 2006;5:2-5/http://www.i-r-i-e.net/inhalt/005/0500_full.pdf.
32. Goodman KW. Review of *Wondergenes: Genetic Enhancement and the Future of Society* (MJ Mehlman, Indiana, 2004). *The Journal of Legal Medicine* 2004;25:257-265.
33. Goodman KW. Using the Web as a research tool. *MD Computing* 2000;17(5):13-14.
34. Goodman KW. Bioinformatics: Challenges revisited. *MD Computing* 1999;16(3):17-20. Reprinted with revisions as Bioinformatics: Challenges at the frontier, in H.T. Tavani, ed., *Ethics, Computing and Genomics*, Boston: Jones and Bartlett, 2006, 317-321.
35. Goodman KW. Commentary: National living wills and local politics. *ASBH Exchange* (newsletter of the American Society for Bioethics and Humanities) 1999; Summer: 6.
36. Goodman KW. Health care ethics. *Responses to an Aging Florida* 1999;Summer: 5-6
37. Goodman KW. Health informatics and the hospital ethics committee. *MD Computing* 1999;16(2):17-20.
38. Goodman KW et al. IRB review: Necessary, nice or needless? (Letter) *Annals of Epidemiology* 1999;9:68-70.
39. Goodman KW. Introduction to informed consent. Part of American College of Medical Genetics Annual Clinical Genetics Meeting workshop (Paradigms for designing informed consent for genetic testing and research), *Genetics in Medicine* 1999;1(2):21 (abstract).
40. Balkany T, Hodges AV, Goodman KW. Additional comments. *Otolaryngology—Head and Neck Surgery* 1998;119(4):312-313.
41. Goodman KW. Ethics of computer prognoses. *Physicians and Computers* 1998;16(2):23-26.
42. Goodman, K. The ethics of CHINs: Community Health Information Networks offer opportunities -- and ethical challenges -- for health care providers. *Physicians and Computers* 1997;15(3):16-19, 23-24.
43. Goodman, K. Business Ethics for Bioethics Committees. *Network News: Newsletter of the Florida Bioethics Network* April 1998: 1-3.
44. Goodman, K. Medical ethics in education, policy review & consultation. *The Record* (Broward County, Florida, Medical Association) 1997;59(5):7-8.
45. Goodman, K. Progress in ethics: from "dilemma fetishism" to genetics and psychiatry. 22nd International Congress on Law and Mental Health, June 1997, Montreal, p. 29 (abstract).
46. Anderson, J, Goodman, K. Ethical issues in informatics and community health. American Medical Informatics Association, Spring Congress, May 1997, San Jose, Calif., Final Program and Abstract Book, p. 99.
47. Coughlin SS, Kass NE, Goodman KW, Pies C. Instruction in Public Health Ethics. American Public Health Association 124th Annual Meeting, Book of Abstracts, 1996, p. 431.
48. Goodman KW. A level playing field: Special programs can help address under-representation of minorities in medical informatics. *Physicians and Computers* 1995;13(4):12-23.

49. Goodman, K. Alternatives to Principle-Based Methods for Ethical Decision Making. *Decision Making in Public Health: Priorities, Power, and Ethics*, San Diego: American Public Health Association, 1995, p.163 (abstract).
50. Goodman, K., Ethics and System Evaluation. *Physicians and Computers* 1994;11.11:12-14
51. Goodman, K. The role and function of hospital ethics committees, *Miami Medicine* 1994;64.7:23-24.
52. Goodman, K. A Budget of Ethical Issues in Computational Medicine. In *Etica y Cultura Contemporánea*, Mendoza, Argentina, EDIUNC, 1994, 57-63
53. Goodman, K. Toward a unified code of ethics in epidemiology. *American Journal of Epidemiology* 1993;138:672 (abstract).
54. Goodman, K. Monitoring ethics, *Physicians and Computers* 10.10; March 1993: 10-12.
55. Goodman, K. Moral arguments for medical volunteerism, *Miami Medicine* 63.11; December 1992: 25.
56. Goodman, K. A question of ethics: the increased capability of computational diagnosis brings with it a host of questions. *Physicians and Computers* 1992;10(4):10-13.
57. Goodman, K. Science policy should be independent of political and ideological concerns. *The Scientist* 1991;5(5)::11,13.
58. Goodman, K. Knowledge and communication. *Amplifier* (American Psychological Association Newsletter on Media Psychology) 1990;6(2):3,8.
59. Goodman KW. Review of T.W. Cooper, ed., *Communication Ethics and Global Change*, (Longman, 1989); *Journal of Mass Media Ethics* 1990;5.1:66-69.
60. Goodman KW. Journalism and philosophy, *Proceedings and Addresses of the American Philosophical Association* 1989;63.5: 35-40.
61. Morrisson S, Kee M, Goodman KW. Analysis. *Machine Translation* 1989;4.1:113-128.

20.a Popular Media, Commentary, etc. (Selections)

Goodman KW, Mack H. Medical professionals have an ethical duty to go digital. *The Miami Herald*, March 3, 2016. Available at <http://www.miamiherald.com/opinion/op-ed/article63913667.html>.

Goodman KW. Why executions can't (and shouldn't) be sterilized. *The Phoenix Republic*, August 17, 2014. Available at <http://www.azcentral.com/story/opinion/op-ed/2014/08/13/medical-executions-joseph-rudolph-wood/14015333/>.

Goodman KW. Ethics, science funding and the fiscal cliff. *Science Progress*, Jan. 7, 2013. <http://scienceprogress.org/2013/01/ethics-science-funding-and-the-fiscal-cliff/>.

Goldschmidt PJ, Goodman KW. The full cost of medical fraud. *The Miami Herald*, Feb. 6, 2010.

Goodman KW. A `Miami Moment': A Minority's Hatred of Fidel Castro Has Many Struggling to Do the Ethical Thing for Elian. *Chicago Tribune*, April 5, 2000, http://articles.chicagotribune.com/2000-04-05/news/0004050081_1_case-of-elian-gonzalez-ethics-moments

Goodman KW. A DiMaggio rule on medical privacy. *The New York Times*, December 30, 1998, A17. PMID:11648103

Numerous other journalistic articles on science, medicine, bioethics and related issues.

20.b Instructional Media

Various contributors. Ethics and Governance of Artificial Intelligence for Health. World Health Organization, 2022, <https://openwho.org/courses/ethics-ai>.

Goodman KW, PI, Ethics Curriculum Project. ECP provides modules on a broad ensemble of issues and topics under the headings Language Arts, Science and Math, Social Science, Arts and Humanities and Special Topics. These modules include content introductions, lesson plans, student activities and knowledge assessment tools. 2005-2015.
http://www.miami.edu/index.php/ethics/projects/ethics_curriculum_project

Goodman KW. Nurse practitioner education in developmental disabilities, Webinar Series, Florida Developmental Disabilities Council, March 2015
[<https://www.youtube.com/watch?v=NcjbNiy7k>].

Goodman KW. Publication and authorship. CITI. <https://www.citiprogram.org/>, 2009-2014.

Goodman KW. Genetic research in human populations. CITI course in the protection of human research subjects. <https://www.citiprogram.org/>, 2003-15.

Cava A, Cushman R, Goodman KW. HIPAA and human subjects research. CITI course in the protection of human research subjects. <https://www.citiprogram.org/>, 2003-2008.

Geissman KW, Goodman KW et al. Scientific Ethics: An Interactive, Multimedia, Computer-Based Training. Atlanta: Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry, 1998.

NB: CITI modules also listed under Section 19, above.

21. Other works accepted for publication:

V. PROFESSIONAL

22. Funded Research Performed:

Current

2 U01DA053941-01 Solo-Gabriele (PI) 2021-2023
This project supports one of the sites for the NIH Rapid Acceleration of Diagnostics (RADx) Initiative, here to sample wastewater to detect COVID and compare with hospital infection data.
NIDA
Role: Co-investigator, 8.33%.

NSF planning Díaz-Pachón 2021-2022

IUCRC Planning Grant University of Miami: Center for Standards and Ethics in Artificial Intelligence (CSEAI)
Role: Co-investigator, 1%

Previous

National Institutes of Health, Clinical and Translational Science Award. Miami-CTSI.
1UL1TR000460 (Szapocznik) 06/27/12 – 05/31/17. Role: Ethics unit coordinator, 20-30%.

Alpha-1 Foundation, Social media as an interactive educational medium for quality of life issues for those with Alpha-1 (Moseley): 07/01/13 – 06/31/15. Role: Investigator, 10%.

National Institutes of Health, Fogarty International Center. Pan American Bioethics Initiative.
1R25TW008186 (Braunschweiger and Goodman) 09/23/08 – 05/31/12, with no-cost extension to 05/31/14. The major goal of this project is to help build capacity in research ethics education in the Latin American and Caribbean regions. Role: Co-PI, 15%.

ARRA Supplement to Fogarty award, 3R25TW008186, to develop additional curricular tools on research ethics for international learners. 9/1/2009-8/31/2011, \$39,908. Role: Co-PI. (Under no-cost extension)

National Center on Minority Health and Health Disparities. A Targeted Decision Aid to Improve Minority Participation in Clinical Trials (1RC2MD004784), Byrne MB, PI, 09/28/2009 – 06/30/2011. NIH – NCMHD/NCI, \$1,652,959. (M. Byrne) The major goal of this project is to develop and assess decision support tools for prospective research participants. Role: Investigator. 5%

Robert Wood Johnson Foundation (Goodman); 12/01/06-02/28/09; 20%
Ethical, Legal and Social Issues, Project HealthDesign \$160,000 (incl. \$10k transition funds). Role: PI, to direct efforts to identify and address ethical, legal and social issues related to the use of personal health records (project number 59879).

Beier J. Vector-Borne Disease Control in Urban Environments. 1 P20 RR020770-03 (NIH Director's Exploratory Centers for Interdisciplinary Research), 09/28/04-07/31/07 (5%).
Role: Co-investigator to coordinate ethics activities as part of development of new interdisciplinary approaches for the control of vector-borne diseases in urban environments, through collaborative studies involving investigators from 11 Departments and Centers at University of Miami, Kenya, Egypt, Israel, Costa Rica, and Trinidad. (\$1,668,869.)

Goodman KW. The CITI Course in the Responsible Conduct of Research – Part B. Office of Research Integrity. \$25,000 curriculum development contract, 2006. Role: PI.

Walsh, P. Atmospheric and Marine-Based Interdisciplinary Environmental Health Training Project, NIEHS, R25 ES10713, 0-20-00—8-31-07 (7-10%). Role: Develop environmental health and ethics curriculum. Co-Investigator.

Scott, G. Fellowship in Clinical Research, NIH, OD-00-002, 9-30-02—9-29-05 (5%). Role: contribute to ethics curriculum.

Shor-Posner, G. Optimizing HIV/TB Management in the HAART Era, NIH Fogarty D43 TW000017-16, 7/29/04—5-31-07 (2-5%). Role: Contribute to ethics activities, including annual conference.

Mack, A., others and Goodman, K, Health Careers Motivation Program , HRSA, D 18 MB 02868-01, 9-1-99—8-31-02, \$623,248 (2-5%). Role: Provide ethics instruction to program participants.

Goodman, KW. principal investigator, Difficult Challenges in Human Subjects Research, U.S. Department of Health and Human Services, National Institutes of Health, NIAID, T15 AI07591, 10-1-99—9-30-02, \$265,986 (15%). Role: As PI, oversee training grant to develop conferences.

Beckwith, S., others and Goodman, K, Community-State Partnerships to Improve Care of the Dying, Robert Wood Johnson Foundation, 1-1-00—12-31-02, \$449,961 (20%). Role: Develop ethics and other resources for end-of-life education project.

O'Connell, M., others and Goodman, K, . Undergraduate Medical Education for the 21st Century, HRSA/AACOM, 240-97-0038, 9-1-98 — 8-31-01, \$375,000 (8%). Role: Contribute to creation of a Web-based training module in managed care ethics.

Goodman, KW. Minority Precollege Health Science Outreach Project; U.S. Department of Health and Human Services, National Institutes of Health, National Center for Research Resources; 5R25RR010242-02, \$219,891; September 1994- September 1997. Role: Coordinate placement of minority students in UM labs.

Goodman, K. principal investigator, Precollege Health Science Outreach Project; U.S. Department of Health and Human Services, National Institutes of Health, National Center for Research Resources; \$58,615; application dates April 1, 1998-March 31, 1999. PI status transferred to colleague as of June 1998 at awardee's request. Role: Coordinate placement of minority students in UM labs.

Goodman, K. principal investigator, Summer Outreach Program, Dade County Public Schools, 1994-1997, \$219,998. Role: Coordinate Miami-Dade County Public Schools minority summer science education program at UM.

Various philanthropic, corporate and other grants in support of UM ethics programs; 1991-2007, approximately \$3,500,000 (including Arsht gift of \$3 million).

Grant-related Consulting

NICHD, R01HD086700, An Interactive Patient-Centered Consent for Research Using Medical Records. University of Florida Department of Community Health and Family Medicine. PI: R. Moseley. Consultant 9/17/15-8/31/18.

Fogarty International Center, R25 TW010026: Research Ethics Education Program in Jordan, University of California at San Diego. PI: W. Al-Delaimy. Consultant 2015-present

NIH SE Best Practice, Challenge Grant, 1 R01 DA029258-01: Ethical issues in broad data sharing for genetic research on addiction: best practices. University of Colorado, Denver. PI: M. Coors. Consultant 2010-11.

23. Editorial responsibilities

Study Sections and Review Panels

National Academies of Sciences, Engineering, and Medicine / U.S. Government Accountability Office (GAO), Artificial Intelligence in Health Care: Benefits and Challenges of Machine Learning Technologies for Medical Diagnostics (GAO-22-104629), 2022

NIH Special Emphasis Panel/Scientific Review Groups 2022/05 ZRG1 BBBP-H (56) and SEIR-H (80), 2022

NIH Native American Research Centers for Health (NARCH), 2021

European Science Foundation / Research Foundation Flanders, 2021

Netherlands Organisation for Scientific Research, Veni Awards grant referee, 2019

Katholieke Universiteit Leuven Research Council, Belgium, grant referee, 2019

European Union, European Research Council, Ethics Review Panel, Horizons 2020; 2014-present (e.g., HORIZON-INFRA-2021-DEV-02, 2022)

European Union, European Research Council, Ethics Review Panel, FP7, 2010-2014

National Institute of Allergy and Infectious Diseases Special Emphasis Panel ZAI1-JBS-A-S1, S2, RFA-12-018: Clinical Trials Units for NIAID Networks, June 2013.

AHRQ, 2011

Wellcome Trust, UK, 2011 (WT095887RR) grant review

HHS Special Emphasis Panel, FOA-OC-HIT-10-001: Health Information Technology, Special Emphasis Panel, Office of the National Coordinator for Health Information Technology, Curriculum Development Centers, 2010.

Maryland Stem Cell Research Fund Peer Review, 2009.

CDC, Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER), study section, FOA RFA TP08-001: Preparedness and Emergency Response Research Centers: A Public Health Systems Approach, 2008.

NIH research ethics Study Section, 2002-2006.

National Science Foundation, Ethics Section, 2004, 2005

Reviewer, Alpha-1 Foundation, 2007-2013

International Advisor, European Union-funded project, "Personalized health monitoring (PHM) – Interdisciplinary research to analyze the relationship between ethics, law and psychosocial as well as medical sciences. Project meeting, Linköping, Sweden, December 1-2, 2011.

Referee

- AAMC Southern Group on Educational Affairs, 2014 annual meeting
- *Acta Bioethica* [n, 2009]
- *Acta Tropica*
- *AMA Journal of Ethics* [2018]
- *Ambulatory Pediatrics*
- *American Journal of Bioethics* [n, 2006]
- *American Journal of Industrial Medicine* [2004]
- *American Journal of Ophthalmology* [2018]
- *Annals of the American Thoracic Society* [2013]
- *Annals of Epidemiology* [n, 2008]
- *Applied Clinical Informatics* [2018; 2]

- Association for Practical and Professional Ethics [n, 2016, 2017]
- *Biomed Central Medical Ethics* [2017]
- BMC *Medical Ethics* [2017]
- *Bulletin of the World Health Organization* [2019]
- *Business & Professional Ethics Journal*
- Cambridge University Press [2015, 2021]
- *CANCER*
- *Chest* [2015]
- *Clinical Radiology* [2019]
- *Computers and the Humanities*
- *Controlled Clinical Trials* [2000]
- Fund for Scientific Research-FNRS, Belgium [2021]
- Global Summit of National Ethics Committees [2016]
- *Human Mutation*
- *Humor* [1990]
- John Wiley & Sons
- *Journal of Abnormal Child Psychology*
- *Journal of the American Medical Informatics Association / JAMIA* [n, 2016, 2017 (2), 2018 (4), 2019 (2), 2020, 2021 (2)]
- *Journal of Bioethical Inquiry* [2016(2), 2020]
- *Journal of Biomedical Discovery and Collaboration*
- *Journal of Biomedical Informatics* [n, 2002, 2015, 2017, 2018]
- *Journal of Business Ethics* [2004]
- *Journal of General Internal Medicine* [n, 2004, 2006, 2016]
- *Journal of Medical Ethics*
- *Journal of Medical Internet Research* [n, 2020]
- *Lancet Digital Health* [2020]
- The Leverhulme Trust [UK, 2021]
- *Machine Translation*
- *Medical Decision Making* [2002]
- *The Medical Journal of Australia*
- MIT Press
- *Molecular Psychiatry* [2018]
- Oxford University Press [2014]
- *Perspectives in Biology and Medicine* [2019]
- *The Pharmacogenomics Journal*
- *PLOS Computational Biology* [2014]
- *PLOS ONE* [2017, 2018, 2022]
- *Proceedings of the American Thoracic Society*
- *Public Health Ethics*
- *Public Health Reports* [2018]
- *Science and Engineering Ethics* [x, 2019]
- Springer [2016]
- *Swiss Medical Weekly* [2017]
- Symposium on Computer Applications in Medical Care (SCAMC)/American Medical Informatics Association Fall Meeting
- Synthese (2021 (2), 2022)
- Synthese Library [2019]
- *Theoretical Medicine* [2021]
- *Trends in Biotechnology*
- UK Medical Research Council / Research and Innovation Future Leaders Fellowships [2020]
- Wellcome Trust
- *Yearbook of Medical Informatics*, International Medical Informatics Association [2018]

Other

Co-editor with E Vayena, Bulletin of the World Health Organization Special theme: [Artificial intelligence in the health sector: ethical considerations](#), 2020.

Reviewer, "Big Data Ethics Framework for Health and Research," National University of Singapore, 2019.

European Science Foundation, College of Expert Reviewers, 2019-present

Section co-editor (with Malin B), International Medical Association, *IMIA Yearbook of Medical Informatics*, 2018

Editor, Ethics and Health Information Technology section, *Cambridge Quarterly of Healthcare Ethics*, 2014-present

External Reviewer

- University of Toronto Joint Centre for Bioethics, January 24, 2011
- University of North Carolina at Chapel Hill School of Medicine, all ethics units, May 7-8, 2007

Editorial Board, *Journal of Biomedical Informatics*, 2014-2021

Associate Member, ALERT (Aspects of Law and Ethics Related to Technology) Research Group, London, UK, 2014-present.

Associate Editor, *Acta Bioethica*, 2010-present

Consultant/reviewer, "WHO Online Research Ethics Training Course," Geneva: World Health Organization, 2013.

Consultant/reviewer, "WHO Strategy on People-Centered and Integrated Health Services," Geneva: World Health Organization, 2014.

Technical expert / peer reviewer, Gibbons MC et al. Impact of Consumer Health Informatics Applications. Evidence Reports/Technology Assessments, No. 188, Agency for Healthcare Quality and Research, 09(10)-E019, Johns Hopkins University, 2009:
<http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=erta188>

Member, Faculty Advisory Board, Department of Institutional Review Ethics and Administration, Nicholas Cardinal Cheong Graduate School for Life, Catholic University of Korea, 2011-12.

Member, Comité Científico Internacional, *Revista Colombiana de Bioética*, 2009-2011.

Reviewer, American Medical Association Council on Ethical and Judicial Affairs report on "Ethical Guidelines for the Use of Electronic Communication between Patients and Physicians," January 2002.

Reviewer, National Academy of Sciences, Institute of Medicine, Committee on Battlefield Radiation Exposure Criteria, 1999. (Document: S Thaul, H O'Maonaigh, eds. *Potential Radiation Exposure in Military Operations*, Washington, D.C.: National Academy Press, 1999.)

Advisor/contributor, 1998-1999, Institute of Medicine, "Strategies to Protect the Health of Deployed U.S. Forces." (Document: LM. Joellenbeck, PK Russell, SB Guze, eds., Medical Follow-Up Agency, Institute of Medicine, *Strategies to Protect the Health of Deployed U.S. Forces: Medical Surveillance, Record Keeping, and Risk Reduction*, Washington, D.C.: National Academy Press, 1999.)

Co-editor, "Scope: Issues and insights" column, *MD Computing*, 1998-2001.

Contributing Editor, *Physicians & Computers*; 1992-2001.

Conference organizer and director, and program editor, annual "Clinical Ethics: Debates, Decisions, Solutions" conference, Bioethics Program, University of Miami, 1994-2010.

Conference organizer and director, Florida Bioethics Network Seventh Annual Conference, "Bioethics in Florida: Challenges in Daily Practice," Tampa, Oct. 8-10, 1997.

Member, Program Directorate and Proceedings Editorial Board, First World Congress on Computational Medicine, Public Health and Biotechnology, April 24-28, 1994, Austin, Texas.

Guest Issue Editor, *Miami Medicine*, special number on bioethics, Vol. 64, No. 7, August 1993.

Symposium organizer and chair, "Computers and Ethics in Medicine," American Association for the Advancement of Science annual meeting, Chicago, Feb. 7, 1992.

Managing editor, *Machine Translation*, quarterly journal of computers and translation published by Kluwer Academic Press; Aug. 1989-Nov. 1991.

Goodman K. Guest Editor, *Machine Translation* 4.1 and 4.2; 1989. Special issues on knowledge-based machine translation.

24. Professional and honorary organizations:

AMIA (American Medical Informatics Association)

- Founder and Chair, Ethical, Legal and Social Issues Working Group, 1996-1998; chair, 2003-2004
- Chair, Ethics Committee, 2008-2014
- Chair, Vendor Contracts Task Force, 2009-2011
- Member, Working Group Steering Committee, 2006-2007
- Member International Affairs Committee, 2014-

Member, American College of Epidemiology Ethics Committee, 1995-1999, 2005-present; chair, 2006-2008.

Co-executive director, Florida Bioethics Network, 1999-2005; director, 2005-present; president, 1997-1998; board member, 1993-1997.

Member, Association for Practical and Professional Ethics, 1995-present. Elected to Board of Directors, 2020.

Member, Director's Advisory Committee, University of Miami Interdisciplinary Stem Cell Institute, 2009-2016.

Member, Advisory Committee, Institute for Ethics in Health Care, Miami-Dade College, 2001-present.

Member, Bioethics Committee, Florida Department of Corrections Health Services, 1994-2002.

Member American Association for the Advancement of Science

Member American Medical Informatics Association

Member American Society for Bioethics and the Humanities

Member Association for Practical and Professional Ethics

Member Florida Bioethics Network; Director, 2004-present

25. Honors and awards:

“Honorary Nurse Award,” UHealth / National Nurses Week, May 2023.

Elected Fellow, The Hastings Center, 2020.

Elected Fellow, American College of Epidemiology, September 2018.

Johnson J, Goodman KW. Writing prose and writing code: unrecognized causes of reproducibility failures. 2017 Innovations in Research and Research Education Award, Association of American Medical Colleges (AAMC), third prize,

<https://www.aamc.org/members/great/479422/2017researchprogramawards.html>;

<http://med.miami.edu/news/aamc-award-focuses-on-improving-science-writing-and-coding>.

See also <https://news.aamc.org/medical-education/article/academic-medicine-research-replication-crisis/>

Inducted University of Miami Iron Arrow Honor Society, November 2015.

Inducted Alpha Omega Alpha Medical Honor Society, March 2012.

Honorable Mention, Dorland Health People Awards, October 2011

(<http://accessintelligence.imirus.com/Mpowered/book/vcip11/i6/p1>).

Leadership Award, AMIA (American Medical Informatics Association), Nov. 13, 2010.

Outstanding Faculty Award nominee, University of Miami Association of Greek Letter Organizations, April 2010.

“Health Care Hero” award nominee, “Individual of Merit,” Greater Miami Chamber of Commerce, May 2009.

Visiting Scholar, Erasmus Mundus Programme in Applied Ethics, Centre for Applied Ethics, Linköping University, Nov. 26-Dec. 4, 2009, Linköping, Sweden.

Elected Fellow, American College of Medical Informatics, American Medical Informatics Association, October 2008.

“Heavy Hitter in Education,” *South Florida Business Review*, June 2006.

“Guardian Angel Award,” South Florida Guardianship Association, March 2003.

Inducted Honorary Member, Golden Key National Honor Society, November 1996.

First place in Florida Philosophical Association 1987 graduate-student paper competition, for “Theoretical Terms”; see above.

M.A. awarded with distinction, University of Essex, 1982.

Rotary Foundation scholarship for work in journalism, applied to post-graduate study at Essex, 1981-1982.

B.S. awarded with high honors by the University of Florida, 1975.

Selected for admission by Kappa Tau Alpha national communications honor society, 1975.

Selected for admission by Phi Kappa Phi national scholastic honor society, 1974.

Florida Society of Newspaper Editors, Spot News Reporting team, Daytona Beach News-Journal, 1981. Society of Newspaper Design, 1987-88 Award of Excellence for News/Sun-Sentinel Front-Page Design and Regularly Appearing Section A teams.

Various travel awards to attend conferences and/or present papers.

26. Post-doctoral fellowships: NA

27. Other professional activities, service:

2023

Goodman KW. Foundations and moral reasoning in research on humans; Informed consent, privacy and Confidentiality; and Conflict of interest in scientific research. Research Ethics – Responsible Conduct of Research, Sudan University of Science and Technology in conjunction with Sudan Ministry of Higher Education and UNESCO Chair in Women, Science and Technology, Khartoum, Sudan, February 13-14.

Goodman KW. Research Ethics. Winn Career Development Award, Diversity in Clinical Trials Award Scholars Forum, Virginia Commonwealth University Massey Cancer Center, online, May 10.

Vasiliu-Feltes I, Blackman R, Goodman KW, Rausch K. Responsible and Trustworthy AI, Institute of Science, Entrepreneurship & Investment, online, May 11.

2022

Goodman KW. Ethics, Informatics and Reproducibility: Local Challenges, Global Duties, Florida International University, Health Policy and Management Department, January 31.

Goodman KW, James J, Kalluri R, Mezgova H. Biased Perspective, Unequal Effects: AI & Healthcare. Science. Ethics & Policy Symposium, University of California at Berkeley, April 9.

Goodman KW. Data Standards and Reproducibility, REDSSA Seminar: The Ethical, Legal and Social Implications (ELSI) of Data Science in Healthcare in sub-Saharan Africa. Stellenbosch University, online, April 11.

Gantt A, Barrett LM, Goodman KW. Healthcare Resource Allocation & the Rationing of Care in the Time of COVID-19. American Bar Association Health Law Section, Emerging Issues in Healthcare Law, Miami, April 29.

Goodman KW. Ethics and Guardianship. 5th Annual Clerks Statewide Investigation Alliance Training Symposium. Florida Clerks and Controllers, online, May 3.

Goodman KW. Guardianship, Ethics and End-of-Life Care. Florida State Guardianship Association, 35th Annual Conference, Sarasota, July 21.

Goodman KW. Epidemiology, Informatics, Ethics: Social Responsibility in a Wobbly Society. American College of Epidemiology Annual Meeting, Scottsdale, Arizona, September 10.

Goodman KW, Greene KG, Klugman C, van den Hoven, J, Wallach W. Operationalizing the WHO Guidelines for AI. Google Health Bioethics Summit 2022, in conjunction with the Hastings Center, online, October 12.

Goodman KW, Tolle S, Blackler L. The Public Role of State Bioethics Organizations in Advancing Ethical Practices and Policies, American Society for Bioethics and the Humanities, Portland, Oregon, October 29.

Goodman KW. Ethics, Epidemiology and Environmental Surveillance. Global Metagenomics Summit: 7th Annual Metagenomics and Metadesign of Subways and Urban Biomes (MetaSUB) Conference, Miami Beach, November 21.

2021

Goodman KW, Hasan M, Kniepmann K. Equity, ethics and issues of faith. Florida Palliative Care Coalition, Inaugural Summit, Orlando, June 5.

Goodman KW, et al., panelists. FDA Virtual Public Workshop on Transparency of AI/ML-enabled Medical Devices. October 14.

Invited participant, National Institute of Standards and Technology (NIST) Workshop, NIST Research Data Framework (RDaF), October 29.

Goodman KW. Digital Death: Managing end-of-life care in electronic medical records. 16th Annual International Conference on Clinical Ethics & Consultation, Stellenbosch University, Cape Town, South Africa, via Zoom, December 2.

2020

Goodman KW. Ethics in guardianship. 1st Annual Symposium on Ethics, Florida State Guardianship Association, Kissimmee, Florida, January 10.

Goodman KW. Session chair / moderator. Pathways to professional social responsibility: the development of personal and professional values in undergraduates (Schiff D, Borenstein J.). Association for Practical and Professional Ethics Annual Meeting, Atlanta, February 22.

Goodman KW. Ethics, software engineering and de-identification: Titrating protections to serve stakeholders' interests. National Cancer Institute Workshop, De-identification of narrative clinical documents: Stakeholders' perspectives and acceptance of machine-based de-identification, Rockville, MD, February 25.

Cannata D, Saab F, Goodman KW. Roundtable: Empowering Women via Ethical Business Values, World Business Angels Investment Forum, via Zoom, August 25.

Goodman KW, Fireside Chat with Charles Jaffe, MD, PhD, HL7 34th Annual Plenary Meeting, videoconference, September 29.
[<https://www.youtube.com/watch?v=PwKMWEFZL7Y&feature=youtu.be>]

Goodman KW. Covid vs. human brains and intelligent machines: Covid is winning. V Colóquio Internacional de Bioética / 5th International Bioethics Colloquium, Pontifical Catholic University of Rio Grande do Sul, Porto Alegre, Brazil, via videoconference, November 4.

Goodman KW. Ethical universals and research ethics: In defense of shared global values. 5th International Conference on Research Ethics in the MENA, Jordan University of Science and Technology, Irbid, Jordan, via videoconference, November 6.

Johnson J, Goodman KW. From compliance to creativity: Struggling to maintain the integrity of research integrity. Research/Reproducibility 2020, University of Florida and ORI, December 2.

Goodman KW. Ethics and Motorsports. International Council of Motorsport Sciences, Annual Congress, via videoconference, December 9.

2019

Weng C, Murphy S, Pathak J, Embi P, Goodman KW (moderator). Enabling medicine-based evidence using large-scale clinical data research networks: State of art, impact, challenges, and future work. American College of Medical Informatics Winter Symposium, Fort Myers, Florida, January 26.

Goodman KW, Roew E, Lipton, Z, Purves D. Legal and ethical issues in medical applications of artificial intelligence. Promise and Problems in Emerging Technology: Shaping the Societal Impact of Artificial Intelligence, University of Florida Department of Philosophy and School of Law, Gainesville, February 28.

Deria R, Goleman L, Goodman KW (moderator). Panel on race and bioscience. American Association for Practical and Professional Ethics Annual Conference, Baltimore, March 2.

Goodman KW. Precision medicine, big data and global science ethics: A U.S. perspective. Korean Parliamentarian Forum on Global Health: The Global Legislation Trends in Precision Medicine and Big Data, Seoul, April 22.

Goodman KW. Meta-Analysis: A Missing Component of RCR Curricula and Ethics Studies of Research Methods. 6th World Conference on Research Integrity; poster. Hong Kong, June 4.

Goodman KW. Direct-to-consumer genetic testing. 18th Gordon L. Snider Critical Issues Workshop: Detection of Alpha-1 Antitrypsin Deficiency: The Past, Present and Future. Alpha-1 Foundation, Orlando, June 23.

Goodman KW. Including ethics advice in electronic health record systems. Ninth Cambridge Consortium for Bioethics Education, Cambridge University Press, Paris, July 4.

Goodman KW. Ethical challenges and opportunities in AI for local and global health (pre-recorded in Beijing). Beijing Summit on Health Data Science, Peking University, Beijing, July 14.

Al-Delaimy W, Forman M, Gaudino J, Goodman KW, Widome R. Epidemiology, Policy and Trust. American College of Epidemiology Annual Meeting, Pasadena, Calif., September 9.

Goodman KW. Historias Clínicas Electrónicas. Universidad de los Andes, Bogota, September 20.

Goodman KW. Data confidentiality, privacy and informed consent. World Health Organization Consultation, Developing WHO Guidance on Ethics & Governance of Artificial Intelligence for Health, Geneva, October 3.

Goodman KW. Ethical and practical issues in dealing with difficult patients. Symposium on Advanced Wound Care, Las Vegas, October 14.

Goodman KW. nursing ethics curriculum development: trans-curricular, inter-professional, multi-modal. American Association of Colleges of Nursing 2019 Baccalaureate Conference, Orlando, November 22.

Goodman KW. Clinical futility: Ethics, law and policy in Florida. Tallahassee Memorial Hospital, December 9.

2018

Trucco M, Unguru Y, Goodman KW. Ethics discussion. FACTOR Osteosarcoma Research Conference, Sylvester Comprehensive Cancer Center, Miami, January 27.

Goodman KW. Clinical futility: Balancing science, ethics, law – and the psychology of hope. Grand Rounds, Moffitt Cancer Center, Tampa, March 23.

Goodman KW. Data ethics and computational bioscience. 9th Annual International Conference on Ethics in Biology, Engineering & Medicine, Florida International University, Miami, April 15.

Goodman KW. Moral challenges of medical machines & Ethics and information technology. Medical University of Pleven, Bulgaria, and Bulgarian Association of Bioethics and Clinical Ethics, April 19.

Goodman KW. Artificial intelligence and health Care. Ethics and AI for Good Health symposium, University of Toronto, June 11.

Goodman KW. Ethics, science and authorship: The growth of knowledge in the 21st century. Third International Conference on Ethics in Jordan. Jordan University of Science and Technology, Irbid, July 3.

Goodman KW. Ethics, information technology and TB. Digital Health Technologies for a World Free of TB (US AID), New Delhi (by videoconference), July 26.

Goodman KW. Ethics discussion. Florida Department of Health Ethics Reaccreditation Workgroup, conference call, July 31.

Goodman KW. Bioethics and precision medicine: From little genes to big data. Total Exposure Health, Pacific Northwest National Laboratory, Bethesda, September 6.

Goodman KW. Ethical challenges in clinical trial recruitment. Alpha-1 Foundation Clinical Resource Center Forum, Miami, September 8.

Goodman KW. Big data, small data and artificial intelligence. Update in Research and Public Health Ethics. World Health Organization, Geneva, September 28.

Goodman KW. Intelligent machines, big data and epidemiology: From ethics to policy. Society for Epidemiologic Research and American College of Epidemiology, joint webinar, October 16.

Goodman KW. Keynote: Big Data ethics, from writing code to coding rights in an era of intelligent machines. Ethics and Responsible Conduct of Research Sessions, Sigma Xi, Annual Meeting, San Francisco, October 27.

Goodman KW, Tierney W, Chute C. ACMI Debate: Biomedical researchers should have access to patient data without their consent. AMIA 2018 Annual Symposium, San Francisco, November 5.

Goodman KW, Reis A. Information technology and universal health coverage: Opportunities and ethical challenges for big data and artificial intelligence, World Congress on Bioethics, Bangalore, India, December 6.

2017

Goodman KW. Big data sharing: Software engineering ethics, reproducibility and curriculum development. Networking and Information Technology Research and Development Program, National Science and Technology Council, Executive Office of the President of the United States, Arlington, VA, January 26.

Goodman KW, Murray GC, Wong A, Hartsfield M. Impact of cost containment initiatives on patient rights and provider liabilities (panel). Sixth Annual Health Law Conference, Center for Innovative Collaboration in Medicine and Law, Tallahassee, February 13.

Goodman KW. Ethical considerations in the use of virtual reality. Ethics in Investigational & Interventional uses of Immersive Virtual Reality (e3iVR), University of Wisconsin-Madison, April 26.

Weber I, Mojova Y, Goodman KW. Social media for health research (tutorial). 11th International Conference on Web and Social Media, Montreal, May 15.

Brosco J, Goodman K, Stone McGuire L. Training medical professionals in the humanities. Medical Humanities Summer Institute, Coral Gables, Florida, May 20.

Goodman KW. Clinical research and the challenge of balancing profit and progress. 2nd International Conference on Ethics in Jordan: Clinical Trials, Jordan University of Science and Technology, Irbid, August 2.

Goodman KW (panel moderator), Peters E, Pinney S, Morain S. Untangling the ethical intersection of epidemiology, human subjects research and public health. American College of Epidemiology Annual Meeting, New Orleans, September 25.

Goodman KW. Presidential Symposium: Ethics and the electronic medical record. Florida Psychiatric Society, Sarasota, October 7.

Harle CA, Kim H, Nelson DR, Goodman KW (moderator). Successes and challenges in developing and implementing electronic informed consent tools for research. AMIA Annual Meeting, Washington, DC, November 6.

Kaplan B, Liaw T, Subbian V, Courtney K, Hochheiser H, Goodman KW. Promoting ethical and professional responsibility in biomedical informatics education. AMIA Annual Meeting, Washington, DC, November 5.

Goodman KW. Patients' duty to share data – because they benefited from the data of others. Ethical, Legal and Social Implications of Learning Health Systems, University of Michigan Department of Learning Health Systems, Ann Arbor, November 15.

Goodman KW. Ethics, epidemiology and ehealth: Managing (very) big data in a networked world. Centers for Disease Control and Prevention Public Health Ethics Committee and the Office of the Associate Director for Science, Atlanta, November 17.

2016

Goodman KW. Death and dying in Florida: FS 765, POLST and daily hospital life. Elder Law Section, Florida Bar, Essentials of Elder Law, Orlando, January 15.

Goodman KW. Ethics and plastic surgery. University of Miami Miller School of Medicine Department of Surgery, Division of Plastic, Aesthetic and Reconstructive Surgery, February 3.

Goodman KW, Gillis M. Ethical issues in death and dying. End-of-Life Conversations, University of Miami Miller School of Medicine Division of Continuing Medical Education, February 27.

Goodman KW. ICT in healthcare: international data sharing. ICT in Healthcare: Legal, Ethical, Social and Governance Challenges, Middlesex University, London, March 11.

Goodman KW, Emerson C, Vayena E, Henry D. Data, big data and really, really big data: Balancing values and advancing policy. 16th Annual Jus Lecture, University of Toronto Dalla Lana School of Public Health and Joint Centre for Bioethics, 27th Annual Canadian Bioethics Society Conference, Toronto, March 28.

Goodman KW. IRB regulatory challenges. Ethical Issues Related to Clinical Research and Rare Diseases, 15th Gordon L. Snider Critical Issues Workshop, Alpha-1 Foundation, Bethesda, April 1.

Goodman KW. Computational epidemiology: Benefits, risks and the duty of citizens to contribute to Big Data. Epidemiology Congress of the Americas, Miami, June 23.

Goodman KW. Intelligent machines and the transformation of health care. International Bioethics Retreat, Cambridge University Press, Paris, July 6.

Goodman KW. The tyranny of privacy: Balancing rights and public health. Service Delivery & Safety Department, eHealth Team, World Health Organization, Geneva, July 22.

Goodman KW. International Data Sharing: Rights, duties and opportunities. International Conference on Ethics and Biomedical Informatics in Jordan, Jordan University of Science and Technology, Irbid, Jordan, August 10.

Goodman KW. Health and Humanitarian Implications of Mass Casualty Events. Mass Casualties: Preparing for the Worst – Providing the Best. Florida Institute for health Innovation, Florida Atlantic University, Boca Raton, September 26.

Goodman KW. Ética y tecnología de la información de la salud: Normas viejas y nuevos desafíos. Congreso Médico Colmédica, Visionarios de la Ciencia: Entre Médico y Paciente, Bogotá, October 20.

2015

Goodman KW. Death and dying in the 21st Century: Have we made any progress? JFK Medical Center Grand Rounds, Atlantis, Florida, January 15.

Goodman KW. Interoperability is an ethical issue – and failure to achieve it is a betrayal of patients. (Cf. September 15, 2014.) Data Management Association, Wisconsin Chapter, Madison, March 12.

Goodman KW. Ethics, health informatics and translational science. Mayo Clinic College of Medicine, Center for Clinical and Translational Science Grand Rounds, Rochester, MN, March 13.

Goodman KW. Balancing consent, privacy and the duty to share: challenges for biobank governance in an electronic era. U.S. Office for Human Research Protections, Research Use of Biospecimens: International Perspectives, teleconference, June 17.

Goodman KW. Helmet Safety, Biohacking and Genetic Enhancement: New Challenges in Science, Sport and Society. Florida State University Center for Innovative Collaboration in Medicine and Law and Atlantic Coast Conference Road Scholar Speaker Series, Tallahassee, October 9.

Goodman KW. Clouds, Nets and Banks: Ethical challenges for international data sharing. International Colloquium on Law, Bioethics & Information Technology, Pontificia Universidade Católica do Rio Grande do Sul (PUCRS), Norwegian-Brazilian-American Initiatives in Neuroscience & the Humanities (University of Bergen, University of Miami and PUCRS' Brain Institute, Law School and School of Humanities), Porto Alegre, Brazil, November 4.

Goodman KW. Ethics and electronic health records: Privacy, professionalism, provider burden, and patient control. Indiana University Center for Bioethics and Center for Law, Ethics and Applied Research in Health Information (CLEAR), Indianapolis, November 12.

Goodman KW. From Terri Schiavo to Jahi McMath: Ethical discussion of end-of-life dilemmas. VII International Symposium on Brain Death and Disorders of Consciousness, Havana, December 10.

2014

Herkert J, Goodman KW, panelists, Author Meets the Critics: *Emerging Pervasive Information and Communication Technologies (PICT): Ethical Challenges, Opportunities and Safeguards*, K. Pimple, ed. Association of Practical and Professional Ethics, Jacksonville, FL, March 1.

Goodman KW. Computational decision support at the bedside: Ethics, policy and practice in an era of intelligent machines. University of Miami Department of Medicine Grand Rounds, April 23.

Goodman KW. Ethics and data mining. Food and Drug Administration Data Mining Council, Silver Spring, MD, April 30.

Goodman KW. Medical ethics and electronic health records. University of Miami Department of Psychiatry and Behavioral Sciences Grand Rounds, May 12.

Goodman KW. Big Data, Intelligent Machines, International Public Policy: The Role of Ethics in 21st- Century Health Information Technology. Middlesex University, Science & Technology School Seminar, London, June 4.

Goodman KW. ethics and health information technology: Learning health care systems in a digital world. Memorial Health Care, Savannah, GA, August 15.

Goodman KW. Digital science: Ethics, governance and best practice. University of Florida IRB Retreat, Gainesville, August 27.

Goodman KW. Interoperability is an ethical issue – and failure to achieve it is a betrayal of our patients. Health Level Seven International, 28th Annual Plenary & Working Group Meeting, Chicago, September 15.

Bouësseau M-C, Goodman KW. Toward equitable access to palliative care. 20th International Congress on Palliative Care, Montreal, September 10.

Arras J, Kukla R, Erwin E, Goodman KW. Contemporary issues in medical research. 12th Annual Graduate Student Conference: Biomedical Epistemology and Bioethics, University of Miami Department of Philosophy, October 17.

Byrne M, Owens D, Gareen I, Goodman KW, Schwartz JS. Lung cancer screening: A debate of practice, policy and science. Society for Medical Decision Making, 36th Annual Meeting, Miami, October 18.

Mandel NS, Bishop EM, Brosco JP, Goodman KW, Mechaber AJ, Mechaber HF. Preserving Empathy Throughout the Clinical Years: Third-Year Debrief Groups. Academy on Communication in Healthcare, Research and Teaching Forum, Orlando, October 2014.

Goodman KW. Learning health systems, ubiquitous surveillance and public health: Duties to share, obligations to protect and Responsibilities to serve. eHealth – Legal, Ethical and Social Challenges workshop, Middlesex University, London, October 28.

Goodman KW. Ethics and health information technology: Learning health care systems in a digital world. University of Texas Health Sciences Center, School of Biomedical Informatics, Research Seminar Series, November 12.

Goodman KW. Replication of research results. 20th National Ethics Councils Forum, European Group on Ethics in Science and New Technologies and National Italian Bioethics Committee, November 19, Rome.

Goodman KW, member, WHO Ad-hoc Technical Advisory Group on Palliative Care and Long Term Care, 10-11 December, Barcelona.

2013

Goodman KW. Health Access, health quality, health reform: The ethical imperative. Health Care Reform: Legal and Ethical Questions about Where We Go from Here, Florida State University Center for Innovative Collaboration in Medicine and Law, Tallahassee, February 4.

Goodman KW. Testing for and communicating about brain death: Managing families' fear, denial and suspicion. University of Miami Department of Neurology Grand Rounds, February 15.

Goodman KW. Clinical futility: Definitions and debates. University of Miami Department of Family Medicine and Community Health, February 20.

Brosco JP, Goodman KW, de Velasco RE. Ethical dilemmas in primary care. PriMed: Primary Medicine Today, University of Miami School of Medicine and Harvard Medical School, Fort Lauderdale, February 28.

Goodman KW. Enough already with horror-show RCR education: Time to emphasize positive duties and values. Third World Congress on Research Integrity, Montreal, May 6.

Goodman KW. Computational decision support at the bedside: ethics, policy and practice in an era of intelligent machines. Johns Hopkins University Division of Health Sciences Informatics, grand rounds, Baltimore, May 17.

Goodman KW. Bioética, ética corporativo y ciencia. Introducción a la Integridad Científica, Colegio Médico del Perú, Lima, Peru, September 25.

Goodman KW. Horrores en la educación en ética de la investigación: tiempo de presentar valores positivos. IV Simposio en Humanismo y Bioética, Universidad de los Andes and Fundación Santa Fe de Bogotá, Bogotá, Colombia, October 21.

Goodman KW. Ethics review for grants in Europe and the United States: Some good ideas in search of a home. Hastings Center, informal lunch talk, Garrison, N.Y., October 30.

Goodman KW. Studying studies, inductions of induction and hearing hearsay: The continuing challenge of computational meta-analysis. American Philosophical Association, Eastern Division, 110th Annual Meeting, APA Committee Session, Epistemology of Medicine, Baltimore, December 28.

2012

Arons P, Goodman KW, Moseley RE. Ethics and the IRB: Issues and options. Second Annual Meeting, Florida Consortium for HIV/AIDS Research, Orlando, January 9.

Goodman KW. The computational futility index: using - and misusing - prognostic scoring systems in end-of-life care. Yale University Interdisciplinary Center for Bioethics, Jerome Medalie End-of-Life Issues Study Group, New Haven, January 11.

Goodman KW. Computational decision support in obstetrics and gynecology: Ethics, policy and practice in an era of intelligent machines. University of Miami Department of Obstetrics and Gynecology, Grand Rounds, January 26.

Goodman KW. Computational decision support at the bedside: Ethics, policy and practice in an era of intelligent machines. New York University Center for Health Informatics & Bioinformatics, New York, March 9.

Goodman KW. Computational diagnosis and prognosis in medicine and surgery: Ethics, policy and practice in an era of intelligent machines. Third Annual Eric Munoz Memorial Lecture, Department of Surgery Grand Rounds, New Jersey Medical School, Newark, March 16.

Goodman KW. Computers, ethics and medicine: Challenges of prognostic scoring systems. JFK Medical Center, Medical Grand Rounds, Atlantis, Florida, March 22.

Goodman KW. Bioética, tecnología de la información y salud. Fifth International Congress of Bioethics, June 4, Toluca, Mexico.

Goodman KW. International Public Health Informatics: Ethics, Policy and Curriculum Development. UNESCO Chair in Bioethics, International Conference on Bioethics Education: Contents, Methods, Trends, Tiberias, Israel, September 4.

Goodman KW. Ethics in epidemiology: Foundations and challenges. American College of Epidemiology Annual Meeting, Chicago, September 9.

Goodman KW. Ethics and universal health care. Florida Association of Free Clinics, Annual Conference, Orlando, September 20.

Goodman KW. Ethics, Computers and public health: Intelligent machines in a dangerous and probabilistic world. Clinical Epidemiology Seminar Series, Center for Clinical Epidemiology and Biostatistics, Department of Biostatistics and Epidemiology, University of Pennsylvania, Philadelphia, September 27.

Goodman KW, Greer JP, Mulvey B. International Health Ethics Panel, American Medical Students Association, Davie, Florida, October 13.

Goodman KW. Digital research: Databases, biobanking and privacy in the 21st Century. University of Florida Clinical and Translational Science Institute, Gainesville, Nov. 1.

Goodman KW. Electronic health records, personal health records, and noncommunicable disease interventions: The role of information technology in the debate over expanding public health practice. American Public Health Association, San Francisco, October 29.

McGraw D, Goodman KW. Balancing personal and population privacy needs. Current Issues in Population Health Informatics for Healthcare and Public Health, AMIA Annual Symposium, Chicago, November 3.

Goodman KW. Privacy and confidentiality in electronic archives. VI Jornada Internacional sobre Actualizaciones en Ética de la Investigación e Integridad Científica, Universidad Austral, Buenos Aires, November 16.

2011

Goodman KW, de Velasco R. Ethical challenges during catastrophic events. Hospital Disaster Planning, Preparations and Response: An All-Hazards Approach, Jackson Health System and University of Miami Miller School of Medicine, Miami, February 17.

Goodman KW, Gray KS, Koontz L, McGraw D, Pritts J. Panel Guidance for Secondary Use of Data, "HIMSS11 – Linking People, Potential and Progress," Orlando, February 20.

Goodman KW, Pouncy CRP. Combining the best of worlds: Business, medicine and legal ethics. Florida International University Professionalism, Ethics and the Legal Profession Distinguished Speaker Series, FIU College of Law, Miami, February 24.

Goodman KW, Palamara A. Healthcare reform, "21st Century Medicine: Surviving the Next Decade," Northwest Medical Center, Hollywood, Fla., May 21.

Goodman KW. Control-A, control-C, control-V: (Im)proper documentation in electronic health records. Indiana University School of Medicine, Department of Medicine, Grand Rounds, July 8.

Massoudi B, Fu P, Holmes JH, Goodman KW, Richards J. Public Health Informatics Planning Domains, Public Health Informatics 2011 Conference, Centers for Disease Control and Prevention, Atlanta, August 22.

Goodman KW. Ethics and health information technology: focus on epidemiology and public health, Internal Ethics Committee, Centers for Disease Control and Prevention, Atlanta, August 23.

Goodman KW. Is irrationality alone ever a marker of incapacity? II International Symposium in Disorders of Consciousness, Havana, December 7.

2010

Goodman KW. Guardianship, Medicine and Ethics: Growing Challenges in End-of-Life Care. Dade County Bar Association Probate and Guardianship Committee, Miami, Feb. 11.

Evans B, Menikoff J, Goodman KW, Youngblood L, Cook K. Appropriate Human-Subject Protections for Research Use of Sentinel System Data. Legal Issues in Active Medical Product Surveillance, Engelberg Center for Health Care Reform at Brookings, Washington, DC, March 8.

Goodman KW. Presentation on the Pan American Bioethics Initiative, Beyond the Boundaries: Toward the Establishment of a University Ethics Center, University of the West Indies, Cave Hill Campus, Bridgetown, Barbados, April 22.

Goodman KW. Sistemas de información, privacidad y confidencialidad. Humanismo y Bioética, Fundación Santa Fe, Bogota, Colombia, April 26.

Hormats RD, Jeffery R, Goodman KW, Cooke J, Schwartz HA. The Responsible Resources Trade, a panel as part of the "Our global challenges: A series of dialogues on the pressing issues of our time." Center for Strategic & International Studies, Washington, May 18.

Goodman KW. Bioética e informática de la salud. VI Seminario Internacional e Interuniversitario de Biomedicina y Derechos Humanos, Fundación Tejerina, Madrid, June 24. [Cf. Chapters, above.]

Goodman KW. Ethics and global health information technology. ETH Lunchtime Seminar, World Health Organization Division of Ethics, Equity, Trade and Human Rights, Geneva, June 28.

Goodman KW. Global perspectives of ethics and evidence-based practice: Impact on healthcare systems in developing countries. Summer Institute on Evidence-Based Practice, UT Health Science Center, San Antonio, July 9.

Goodman KW, Zamora E. The guardianship grandstand. Florida State Guardianship Association, Palm Beach Gardens, Fla., July 17.

Goodman KW and others, Steering Committee, 5th Annual Invitational Health Policy Meeting. The Future of Health IT: Innovations and Informatics, American Medical Informatics Association, Reston, VA, Sept. 1-2.

Goodman KW. Medicare and Medicaid Fraud. Plenary presentation, 5th Annual Invitational Health Policy Meeting. The Future of Health IT: Innovations and Informatics, American Medical Informatics Association, Reston, VA, Sept. 2.

Goodman KW. Ethical Universals -- are there any and, if so, what good are they for global health research? Global Perspective Lecture Series, University of California at San Diego, Division of Global Health, Department of Family and Preventive Medicine, San Diego, Sept. 14.

Goodman KW. From "gee-whiz" science to "gee-whiz" ethics: Explaining 21st-century medical challenges to lay audiences. American Association of Medical Colleges, Group on Institutional Advancement, AAMC annual meeting, Washington, D.C., Nov. 7.

Goodman KW. Ethical challenges in electronic health records and information technology. Ethical Perspectives in Healthcare – Today's Challenges, Morton Plant Mease Hospital, BayCare Health System, St. Petersburg, Florida, November 10.

Goodman KW, Kinzbrunner BM. End-of-Life Issues, South Florida Center for Jewish Ethics, Miami Beach, Nov. 18.

2009

Goodman KW. Ethics and health information technology: New challenges in clinical care and research in a pharmacogenomic world. Indiana University Center for Bioethics, Indianapolis, January 29.

Goodman KW. Post-study responsibilities, Building Ethics Models for Global Research, International Association for Dental Research, 38th Annual Meeting, Miami Beach, April 2.

Goodman KW, discussant; Massoudi BL, moderator. The Promise of Electronic Health Information. RTI Fellow Program, Research Triangle Institute, Washington, DC, April 9.

Goodman KW. "Octomom" – What's wrong and what's right with reproductive ethics and the law. Florida Bar Health Law Section, Florida Bar Annual Convention, Orlando, June 26.

Goodman KW. Ethics, capacity assessment and psychiatric practice. 31st International Congress on Law and Mental Health, New York, July 1.

Esposito K, Goodman KW. Law as therapy, therapy as public policy: Ethical comforts – and challenges – in the rise of therapeutic jurisprudence. 31st International Congress on Law and Mental Health, New York, July 3.

Goodman KW. Sects, smoking, drinking and other irrational behaviors: Challenges posed by wards' injurious behaviors. Florida State Guardianship Association, annual meeting, St. Petersburg, August 7.

Goodman KW. HIPAA challenges: From Hippocrates to Obama. Florida State Guardianship Association, annual meeting, St. Petersburg, August 8.

Goodman KW. Professionalism and medical ethics. Florida Gastroenterologic Society, Annual Meeting, Boca Raton, Florida, Sept. 12.

Goodman KW. Privacy and confidentiality in research. Integridad Científica: La Importancia de la Educación en Ética de la Investigación, Pan American Bioethics Initiative, San Jose, Costa Rica, September 18.

Goodman KW. Ethical challenges in neurology: Cases and controversies. University of Miami Department of Neurology Grand Rounds, Oct. 23.

Goodman KW. Ethics at the end of life. Vitas Health Care Hospice Symposium, Davie, Florida, Nov. 9,

Koppel R, Kreda D, Kuperman G, Goodman KW, Zych, Shortliffe EH. Vendor contracts and the Koppel-Kreda *JAMA* article on hold-harmless and non-disclosure clauses. Annual Symposium, American Medical Informatics Association, San Francisco, Nov. 17.

Nichols-Johnson V, Koppel R, Goodman KW, Zych E, Wiederhold G. The electronic medical record and the health of your privacy. Annual Symposium, American Medical Informatics Association, San Francisco, Nov. 18.

Goodman KW. Death, Politics, Disease and Mutation: Some Ethical, Legal and Social Issues for the 21st Century (Part 1). University of Miami Department of Medicine, Division of General Internal Medicine Grand Rounds, Dec. 22.

2008

Goodman KW. Evidence, ethics and expertise: Honest persuasion in opening statements and closing arguments. Federal Court Practice Committee, Florida Bar Midyear Meeting, Miami, Jan. 17.

Goodman KW. On the need for robust research ethics curricula. Eighth Conference, Faculty of Pure and Applied Science, University of the West Indies, Kingston, Jamaica, Feb. 26.

Goodman KW. Practical research ethics: How to manage cases that are hard, really hard and nearly impossible. Eighth Conference, Faculty of Pure and Applied Science, University of the West Indies, Kingston, Jamaica, Feb. 27.

Goodman KW. Ethics for the practicing physician. London Foundation Seminar, keynote speaker/grand rounds, Mount Sinai Medical Center, Miami Beach, March 28.

Goodman KW, Horan TA, Kaelber D, Yasnoff WA. Personal health records in disability communities. American Medical Informatics Association Spring Congress, Phoenix, May 30, 2008.

Goodman KW. Panelist. InfoLinks Virtual Panel on Patient Privacy Rights, Public Health, & Ethics, Division of Alliance Management & Consultation, National Center for Public Health Informatics, Centers for Disease Control & Prevention, June 17.

Goodman KW. Panelist. Epistemological Convergence between Bioethics and Evidence-Based Medicine, as part of the First Costa Rican Bioethics Conference at the National University of Costa Rica in San Jose, in conjunction with the Seventh Annual Iberoamerican Cochrane Network Annual Meeting, the Fifth Annual Iberoamerican Clinical Practice Guidelines Network Meeting and the Second Central American Branch of the Iberoamerican Cochrane Network, San Jose, Costa Rica, June 26.

Goodman KW. HIPAA, privacy and confidentiality: Ethical and legal issues. Florida Children and Youth Cabinet, Fort Myers, July 14.

Brennan P, Goodman KW, Massoudi B, Nugent L. Project HealthDesign: Rethinking the power and potential of personal health records. Summer Institute in Nursing Informatics, University of Maryland School of Nursing, Baltimore, July 19.

Bell K, Diamond CC, Goodman KW, Ralston JD. Policy implications. New Frontiers in Personal Health Records: A "Report Out" from Project HealthDesign and Forum on Next-Generation PHRs. Washington, D.C., September 17, 2008.

Goodman KW. Ethics and epidemiology: Focus on international research. University of Miami Department of Epidemiology and Public Health Grand Rounds, October 15.

Goodman KW. Commentary on EBM and Clinical Practice (M. Tonelli), Critical debates in Evidence-Based Medicine (EBM): Where We've Been and Where We're Going, University of Toronto, November 16.

Goodman KW, Kearns K, Rawlins L, Taylor C. Future of software: Health IT Roundtable. Challenges and opportunities in the new political environment. Business Software Alliance Annual Retreat, Coral Gables, Florida, November 18, 2008.

Goodman KW. Pautas internacionales en Ética de investigación. Maestría en Bioética: Foro Permanente en Bioética: en Colaboración Científica Internacional. Universidad Nacional de Cuyo and Hospital Pediátrico Dr. Humberto J. Notti, Mendoza, Argentina, December 1, 2008.

Goodman KW. Manejo de la información, confidencialidad y privacidad. Maestría en Bioética: Foro Permanente en Bioética: en Colaboración Científica Internacional. Universidad Nacional de Cuyo and Hospital Pediátrico Dr. Humberto J. Notti, Mendoza, Argentina, December 3, 2008.

2007

Goodman KW. Protecting privacy in the Electronic Age: Evidence, ethics and expertise. Federal Court Practice Committee, the Florida Bar Midyear Meeting, Miami, Jan. 18.

Brummel-Smith K, Goodman KW. Ethical decision-making: Quality of life vs. longevity. Florida Geriatric Care Managers Association, Annual Conference, Tampa, Jan. 20.

Goodman KW, Zuroweste E, Paoletti S. A critical look at the health and human rights of economic migrants. Plenary panel, Global Health Education Consortium, 16th Annual Conference, Santo Domingo, Dominican Republic, Feb. 17.

Barrett DH, Hood R, Fiore RN, Goodman KW. Development of an ethics process for pandemic preparedness and response. Association for Practical and Professional Ethics, 16th Annual Meeting, Cincinnati, Feb. 24.

Goodman KW. Bioethics: the changing medical landscape. New College Library Association, Sarasota, March 6.

Sharma TS, Goodman KW, Wilkinson J. Mandatory universal newborn screening for HIV. University of Miami Department of Pediatrics Grand Rounds, March 13.

Flint K, Galland J, Goodman KW. Creating a dynamic program on the responsible conduct of research. National Postdoctoral Association Annual Meeting, Berkeley, CA, April 1.

Fiore RN, Moseley R, Goodman KW (panel). Bioethics in Florida: Challenges for the next decade. Florida Bioethics network annual spring meeting, Miami Beach, April 27.

Goodman KW Ethics in health policy. Bioethics Society of the English-Speaking Caribbean (BSEC), Montego Bay, Jamaica, May 5.

Fiore RN, Laitner M, Goodman KW, Melby G, Gavras J (panel). Floridians' decisions: Genetics, Pandemics and bioethics, Leadership Florida Gulfstream Region, Jupiter, May 14.

Goodman KW. Ethics and vulnerability: Shared responsibilities for infant mental health. Seventh Annual Infant Mental Health Conference, Fort Lauderdale, Fla., May 18.

Goodman KW (moderator). Medical decisions vs. religious beliefs. Florida State Guardianship Association, 20th Annual Conference, Westin, Fla., Aug. 4.

Goodman KW (moderator). Ethics. International Society for Craniofacial Surgery, Salvador, Brazil, August 23.

Goodman KW. When may health professionals refuse to provide care? Baptist Health South Florida, Mariners Hospital, Tavernier, Fla., September 7; and Baptist Hospital, Oct. 24.

Goodman KW. Banked tissue research: Time for a reappraisal. University of Miami Miller School of Medicine Human Subjects Protection Seminar, Sept. 25.

Goodman KW. End-of-life care in a post-Schiavo world. University of Miami Miller School of Medicine, Department of Medicine Grand Rounds, Sept. 26.

Goodman KW. IT, HIPAA, 45CFR46 & ICMJE: E-T-H-I-C-S. The Children's Health Fund, National Annual Meeting, White Plains, NY, Oct. 11.

Goodman KW, The MRSA School Outbreaks: Reflections on an Emerging(?) Epidemic. American Society for Bioethics and the Humanities, Washington, D.C., Oct. 20.

2006

Nogueras D, Goodman KW, Davis H. Powerful Thinkers: A protocol for addressing ethical and moral decision making in high school students. 4th International Civic Education Conference, Orlando, Jan. 20.

Goodman KW. Clinical practice without clinical trials: Ethical issues in off-label drug use. Bascom Palmer Eye Institute, Angiogenesis 2006 Conference, Miami, Feb. 4.

Goodman KW. Discussant. Clinical Ethics Case Presentation, "Futility of Care." University of the West Indies (Cave Hill) and Queen Elizabeth Hospital, Bridgetown, Barbados, Feb. 11.

Goodman KW. Ethics, schmethics: The Schiavo case and the culture wars. The Schiavo Case: Interdisciplinary Perspectives, University of Miami Law Review symposium, Coral Gables, Feb. 18.

Goodman KW. Ethics and social work. University of Miami Miller School of Medicine Department of Pediatrics, Social Work Division, Social Work Grand Rounds, March 28.

Goodman KW. Ethics at the end of life. Blue Cross Blue Shield Center for Ethics, Public Policy and the Professions, University of North Florida, Jacksonville, May 11.

Goodman KW. Ethics, genomics and computing. American Medical Informatics Association, Spring Congress, Phoenix, May 17.

Goodman KW. Ethics and guardianship, Cases you hope you never see. Florida State Guardianship Association annual conference, Orlando, Aug. 4.

Goodman KW. Panel chair, Ethics and Aging: Challenges in Medicine, Nursing and the Law, 2006 Florida Conference on Aging, Tampa, Aug. 14.

Goodman KW. Ethics in a changing elder law environment. Florida Bar Elder Law Section annual retreat, Duck Key, Fla., Sept. 9

Goodman KW. Advance directives in Florida post-Schiavo and POLST: Lessons learned in avoiding future debacles, "End-of-Life Care in Florida – 2006: Current Practice and Future Developments," University Hospital and Medical Center and VITAS Innovative Hospice Care, Tamarac, Sept. 15.

Goodman KW. Ethics and bioinformatics. UM School of Medicine Tuesday Genetics Conference, Department of Pediatrics, Sept. 26.

Goodman KW, Mullings A. Intensive course on biomedical research ethics. University of the West Indies, St. Augustine, Trinidad & Tobago, Oct. 9-10.

Goodman KW. Ethics and plastic surgery. University of Miami Department of Surgery, Division of Plastic Surgery Grand Rounds, Oct. 25.

Goodman KW. Panelist. Is there a future and promise in stem cell research? South Florida Bioscience Consortium & South Florida Hospital and Healthcare Association, Davie, Fla., Oct. 26.

Goodman KW. Pharmacogenomics and human subjects research: New challenges for IRBs. Baptist Health South Florida, Sixth Annual Educational Retreat, Naples, Oct. 28.

Goodman KW. Panelist. Uncertain health informatics decisions: How should we address them. American Medical Informatics Association Annual Symposium, Washington, Nov. 14.

Goodman KW. Bioterrorism and pandemic preparedness. Public Health Ethics, Policy and Law course, The Wharton School, University of Pennsylvania, Philadelphia, Nov. 14.

Goodman KW. When the law is silent: Managing public health emergencies. Federal Judicial Law Clerks seminar, U.S. Federal Courthouse, Miami, Nov. 16.

Goodman KW, Panel moderator. Medical and legal challenges of long-term-care policies. Miami Area Geriatric Education Center, 15th Annual Advances in Geriatrics conference, Fort Lauderdale, Dec. 2.

2005

Goodman KW. Glowfish, racism and other oddities: Ethical challenges in environmental genomics. Florida A&M University, Environmental Sciences Institute, Tallahassee, Feb. 4.

Goodman KW. Ethical issues on obstetrics and gynecology: Focus on cord blood banking. University of Miami Miller School of Medicine Department of Obstetrics and Gynecology Grand Rounds, March 10.

Goodman KW. Embryonic stem cells: Hope for the future or ethical minefield? American Academy of Neurology 2005 Annual Meeting, Miami Beach, April 16.

Goodman KW. Arguments in favor of embryonic stem cell research. National Multiple Sclerosis Society Task Force on Stem Cell Research, Washington, D.C., May 10.

Goodman KW. Ethics in pediatrics. Florida Pediatric Society annual meeting, Orlando, June 11.

Goodman KE. Ethics, technology and healthcare. Biotecnología, Genómica y Bioética, Sus Implicancias en Salud Pública, Pan American Health Organization and Hospital Clínico Universidad de Chile, Santiago, July 15 (in Spanish).

Goodman KW. Disability and guardianship in the post-Schiavo era. Invited keynote presentation, Florida State Guardianship Association, 18th Annual Conference, Doral, Fla., Aug. 6.

Goodman KW. Information, evidence and technological uncertainty: Implications for environmental ethics. Federación Latinoamericana y del Caribe de Instituciones de Bioética (FELAIBE), 5^o Congreso de Bioética, Panama City, Panama, Aug. 10.

Goodman KW. Public understanding of bioethics: Media successes, failures – and duties. Federación Latinoamericana y del Caribe de Instituciones de Bioética (FELAIBE), 5^o Congreso de Bioética, Panama City, Panama, Aug. 10.

Schneider J, Spike J, Goodman KW. Ethics and aging: Priorities for the 21st century. Florida Council on Aging annual meeting, Orlando, Aug. 24.

Goodman KW. Ethics and Medicaid planning. Florida Bar Elder Law Section annual retreat, Naples, Florida, Sept. 17.

Goodman KW. Medical futility. Baptist Health System Conversations in Ethics, South Miami Hospital, Sept. 30.

Goodman KW. The Terri Schiavo case. University of Miami Miller School of Medicine Department of Medicine Grand Rounds, Oct. 19.

Goodman KW. Secret science: Pressures to hide – and sell – drug research data. University of Miami Miller School of Medicine MD/PhD Program Grand Rounds, Nov. 10

2004

Goodman KW. Applying ethics in a real-life medical setting. Understanding the Law and Healthcare Decision Making: Could the Schiavo Case Happen to You? Sarasota County Bar Association, Sarasota, Fla., Jan. 10.

Barron TJ, Powers R, Goodman KW. Ethics, caregiving and the law. Florida Alzheimer's Summit 2004, Tallahassee, Feb. 5.

Goodman KW. Ethics in cancer care. Joint Cancer Conference of the Florida Universities, Orlando, Feb. 6. (And moderator, Workshop on Ethical and Complex Issues in Cancer Care.)

Goodman KW. Evidence, error, ethics: How science and morality intersect in clinical practice. American College of Medical Quality/American College of Preventive Medicine joint annual conference, Orlando, Feb. 20 (Nigel Roberts Award Lecture in Healthcare Ethics).

Goodman KW. The sad case of Terri Schiavo: Easy ethics, weird politics, faulty law. Keynote speech, Academy of Florida Elder Law Attorneys (AFELA), Fort Lauderdale, March 12; Tampa, March 13.

Goodman KW. Panelist, Research at international sites: Whose standards apply? Recognizing and Protecting Vulnerable Subjects: Theory, Practice and Compliance, U.S. Office for Human Research Protections (OHRP), Orlando, April 2.

Goodman KW. Panelist, Protecting the cognitively impaired research participant. Recognizing and Protecting Vulnerable Subjects: Theory, Practice and Compliance, U.S. Office for Human Research Protections (OHRP), Orlando, April 2.

Goodman KW. Bioterrorism, guest speaker, Public Health Policy, Ethics and Law, University of Pennsylvania School of Medicine, April 6.

Goodman KW. Ethical, legal and social implications of genetics. Genetics: The Health Care Genie Coming out of the Bottle, Nova Southeastern University College of Osteopathic Medicine, Master of Public Health Program, May 1.

Goodman KW. ID ethics: Treatment, genetics and public health. UM Infectious Diseases/HIV Grand Rounds, May 3.

Goodman KW. HIPAA as applied ethics. Bioethics in Contemporary Clinical Practice, Palm Beach County Legal Aid Society Bioethics Law Project, West Palm Beach, May 14.

Goodman KW. Ethics and patient records: making the most of outcomes research, error reduction and evidence-based practice; & Ethics and patient records: From HIPAA to decision support. Toward an Electronic Patient Record (TEPR) Annual Convention, Fort Lauderdale, May 20.

Goodman KW, Black K, Jackson MA. What the Schiavo case means to health care decision makers. Florida Council on Aging / Florida Conference on Aging, Miami, Aug. 31.

Goodman KW, small group leader, Prevention and Public Health Working Group business meeting, American Medical Informatics Association, San Francisco, September 9.

Goodman KW, panelist, Gender and role identity in IT design and use. International Medical Informatics Association, Medinfo, San Francisco, September 10.

Goodman KW. Trust me: New challenges in conflict, advocacy and social commitment. American College of Epidemiology Annual Scientific Sessions, Boston, September 13.

Goodman KW. Human suffering: Ethical, social and cultural considerations. Hospice of Naples, Naples, Florida, Oct. 9.

Goodman KW. Ethics and diversity. Miami Area Geriatric Education Center Ethno-Geriatrics Conference, Miami, Oct. 14.

Goodman KW. Ethical controversies in dermatology practice. Miami Society for Dermatology and Cutaneous Surgery, Miami, Oct. 21. (Lecture follows clinical rounds and case presentations.).

Goodman KW. Panelist, Law and ethics of bloodless medicine, International Symposium in Blood Management, UMSM, Miami Beach, Nov. 12

2003

Leon MB, Goodman KW. Conflicts of interest in the lab. 15th International Symposium on Endovascular Therapy, Miami Beach, Jan. 20.

Goodman KW. Ethics and evidence-based psychiatry. Masters of Psychiatry, Florida Psychiatric Society, Miami Beach, Feb. 23.

Goodman KW, with Trotter G and Middleton JR. Panel: Author meets the critics: *Ethics and Evidence-Based Medicine*. Association for Practical and Professional Ethics, 12th Annual Meeting, Charlotte, N.C., March 1.

Goodman KW. Training in ethics: A curricular requirement? American Gastroenterological Association Training Directors' Workshop, Advancing GI Fellowship Training, Chicago, March 23.

Goodman KW. ID Ethics: Genetics, Treatment and Public Health. UM Department of Medicine Division of Infection Diseases Grand Rounds, March 25.

Goodman KW. Ética en investigación internacional. VIII Curso Internacional de Enfermedades Infecciosas, IX Seminario Integral del Sida, Corporación de Lucha Contra el Sida, Cali, Colombia, April 11.

Panelist. Orchestration of business and science in the public interest: Protection of patient rights when developing and testing new drugs. Association for Research in Vision and Ophthalmology Annual Meeting, Fort Lauderdale, May 5.

Goodman KW. Death, stroke and disability: Ethical issues in managing complexity and uncertainty. Annual Stroke Conference, South Miami Hospital and American Stroke Association, South Miami, May 16.

Facilitating expert, American Medical Informatics Association 2003 Spring Congress, "Bridging the Digital Divide: Informatics and Vulnerable Populations," Philadelphia, May 28-30.

Facilitator, U.S. Department of Health and Human Services, Developing a National Agenda for National Health Information Infrastructure, Privacy and Confidentiality Track, Washington, D.C., June 30-July 2.

Goodman KW. HIPAA. Florida Bar Elder Law Section 2003 Retreat, Duck Key, Florida, July 26.

Goodman KW. Technology and ethics, keynote presentation, Eighth Annual Community Bioethics Consortium, Panama City, Fla., Sept. 5.

Gertel A, Goodman KW, Singer G, Gyi F. Panel, Communicating science and medicine to the public: an ethics exploration of power and perception. American Medical Writers Association, 63rd Annual Meeting, Miami, Sept. 19.

Goodman KW. Ethics in Ob-Gyn. University of Miami Department of Obstetrics and Gynecology Grand Rounds, Sept. 18.

Goodman KW. Ethics issues in creating, using, studying and sharing patient registries. Impact of Genotyping Testing: Ethical, Legal, and Social Issues, Alpha-1 Foundation Gordon L. Snider Critical Issues Workshop Series No. 8, Coral Gables, Fla., Oct. 10.

Panel Moderator, Medical and ethical issues involved in aging, Florida Bar Continuing Legal Education Committee, Miami Lakes, Nov. 7.

Goodman KW. Informed consent and the role of IRBs. Arizona State University College of Law, guest lecture, "Bioethics and Genetics in an Intercultural Context" course, Prof. Joan L. McGregor, Nov. 19, 2003, Tempe, Ariz.

2002

Goodman KW. Ethics, law and policy: Sometimes there's no dilemma at all. Presentation, Florida Hospice and Palliative Care, 17th Annual Symposium, Orlando, Jan. 10.

Goodman KW. From Hippocrates to digital genetics. UM Masters of Pediatrics annual conference, Miami Beach, Jan. 19.

Goodman KW. Public health and bioterrorism: How can we prepare? Association of Subspecialty Professors Leadership Conference, Miami, Feb. 1.

Goodman KW. Ethical, legal and social issues in medical informatics. Visiting lecture, MINF 515, Oregon Health Sciences University, Portland, March 7.

Goodman KW. Medical informatics: The connective tissue in privacy, integrity and IRB Education. Oregon Health Sciences University research conference, Portland, March 8.

Goodman KW. Health care ethics. Session moderator, Academy of Florida Elder Law Attorneys, Fort Lauderdale, March 15.

Goodman KW. Health care ethics. Session moderator, Academy of Florida Elder Law Attorneys, Tampa, March 16.

Goodman KW, Ethics, genomics and computing: Searching for standards in research, error management and public health. Centers for Disease Control and Prevention, Office of Genetics & Disease Prevention, April 11, Atlanta.

Goodman KW. Ethical aspects of stem cell research. Nova Southeastern University College of Osteopathic Medicine, 7th Annual Kaleidoscope Conference, Fort Lauderdale, April 14.

Goodman KW. Ethics, cost and public health: The new meaning of evidence-based practice. Institute for Ethics in Health Care, Miami-Dade Community College, Miami, April 24.

Goodman KW. Introduction to ethics education. National Institute of Environmental Health Sciences, annual grantee meeting, Environmental Health Sciences as an Integrative Context for Learning, Rutgers University, Piscataway, N.J., May 10.

Goodman KW. Organizer and moderator, "Multicultural Panel," Florida State Guardianship Association, 15th Annual Conference, Fort Lauderdale, Aug. 3.

Panelist, with Sami Al-Arian, University of South Florida; Judith L. Kreeger, Circuit Judge, Miami-Dade County; Nawar Shora, Legal Adviser, Arab-American Anti-Discrimination Committee, Washington, D.C.; and moderator Susan Dente Ross, Washington State University. The Association for Education in Journalism and Mass Communication annual conference, Law, Media Ethics, Mass Communication and Society and Communication Technology and Policy Divisions, mini-plenary session: Terrorism's Attack on Freedom of Speech and Information, Miami Beach, Aug. 9.

Goodman KW. Health privacy: Ethics committees and HIPAA. Shands at UF Ethics Committee Workshop, Gainesville, Sept. 18, 2002.

Goodman KW. Ethically optimized decision making. As part of "The call we dread, the case we dread: Medical crisis/end-of-life decision making" (panel), 2002 Florida College of Advanced Judicial Studies, St. Petersburg Beach, Sept. 26.

Goodman KW. Official Opening/Public Lecture, Grand Bahama Medical & Dental Association Scientific Conference, Freeport, Bahamas, Oct. 4.

Reiser B, Goodman K. Ethics and guardianship, Miami-Dade Coalition on Aging, "The Aging Puzzle: Pulling the Pieces Together," Miami, Nov. 8.

Goodman KW, Dahm L, Tarczy-Hornoch P, Winkelstein P. Ethics and bioinformatics. American Medical Informatics Association Annual Symposium, San Antonio, Nov. 13.

Goodman KW. Ethics and community health: Power and vulnerability in pediatric practice. Department of Pediatrics Grand Rounds, UM School of Medicine, Nov. 19.

Goodman KW. Ethics with teeth: Clinical and research implications of new federal privacy rules. Department of Dermatology Grand Rounds, UM School of Medicine, Nov. 20.

Goodman KW. Ethics, genes, science: Local values or global norms. Colloquium, Arizona State University College of Education and Lincoln Center for Applied Ethics, Tempe, Nov. 21.

2001

Goodman KW. Foundations of medical ethics. M-1 medical class, Nova Southeastern University College of Osteopathic Medicine, Fort Lauderdale, Jan. 9

Denker A-L, Goodman KW, Wurm G, Novo M. Controversial health policy issues and child health: Vaccines, adolescent confidentiality, parental notification, etc. Masters of Pediatrics, University of Miami Departments of Pediatrics and Dermatology, Miami Beach, Jan. 19.

Denker A-L, Djokic B, Goodman KW. HIPAA. Masters of Pediatrics, University of Miami Departments of Pediatrics and Dermatology, Miami Beach, Jan. 21.

Panelist, Neuroethics/Neuroscience Grand Rounds, University of Miami School of Medicine, Feb. 9.

Goodman KW. Pain, death and privacy: Ethics as a practical problem solver. Collier County Medical Society, Naples, Fla., Feb. 15.

Goodman, KW. Sex, death and managed care: The role of the hospital ethics committee. Naples Community Hospital, Naples, Feb. 15.

Mullings A, Goodman K, Aarons D. An introduction to ethics in epidemiology: A short public health elective course, Department of Community Health and Psychiatry, University of the West Indies, Mona, Jamaica, Feb. 21-23.

Goodman KW. Mad cows, gene maps and Higgs bosons: How social forces shape scientific competition and progress. Sigma Xi science honor society, South Florida branch, Coral Gables, Fla. March 6

Goodman, KW. Invited participant, U.S. Department of Veterans Affairs, State of the Art Conference, "Making Informed Consent Meaningful," Washington, D.C., March 7-8.

Goodman KW. Ethical and social issues in telemedicine. East Carolina University, Brody School of Medicine, Information Technology & Health Care: Ethical, Legal and Social Issues, Greenville, N.C., March 9.

Goodman, KW. Ethics and Evidence-Based Medicine, keynote presentation, PriMed: Primary Medicine Today, University of Miami School of Medicine and Harvard Medical School, Fort Lauderdale, March 23.

Goodman KW. Responsible Conduct of Research: Focus on Epidemiology and Public Health, State University of New York at Buffalo, May 11.

Goodman, KW. facilitator, rapporteur. Privacy, Confidentiality and Security, American Medical Informatics Association Spring Symposium, Atlanta, May 15-17.

Goodman, KW. Health care ethics. Academy of Florida Elder Law Attorneys, Fort Lauderdale, May 19.

Goodman, KW. Invited seminar on research ethics, Division of Epidemiology, Statistics & Prevention Research, National Institute of Child Health & Human Development, Rockville, MD., May 24. (Cases: vitamin supplement RCT in China; medical examiner and drowning data collection)

Goodman KW, Brito A. Extreme ethics: Core issues and difficult challenges in epidemiology and public health. (Workshop abstract: *American Journal of Epidemiology* 2001;153(11):S2.) Invited workshop presentation June 13, 2001, Toronto, Congress of Epidemiology, a joint meeting of the American College of Epidemiology, American Public Health Association (Epidemiology Section), Canadian Society for Epidemiology and Biostatistics, Society for Epidemiologic Research.

Goodman KW, Hendricks JE, Rothenberg A, Reiser B. Developing an ethics consultation service for courts and guardians. Annual Conference, National Guardianship Association, Delray Beach, Oct. 22.

Goodman KW. Research ethics. Barry University School of Natural and Health Sciences, Miami, Oct. 29.

Goodman KW. Evidence, error and uncertainty: Ethical and social challenges for health informatics. Tutorial, American Medical Informatics Association Annual Symposium, Washington, D.C., Nov. 4.

Winkelstein P, Goodman KW. HIPAA: Is government regulation of ethics possible? American Medical Informatics Association Annual Symposium, Washington, D.C., Nov. 7.

Goodman KW, discussant: Why is health critical to the region's long-term development? Dante B. Fascell North-South Center (University of Miami) and The American Assembly (Columbia University), New Challenges to Development for the Democracies of the Americas: Energy, Health and Regional Security, Miami, Nov. 8.

Goodman KW, Matthews CR. Ethics in the correctional system. Florida Chapter, American Correctional Health Services Administration, Orlando, Nov. 10.

Goodman KW. Ethics: Animal models and surgical procedures. Animal Studies Training Workshop, VA Medical Center, Miami, Nov. 29.

Goodman KW. Research ethics, patient privacy and federal regulations: Burdens and benefits. UM Department of Orthopedics and Rehabilitation Grand Rounds, Nov. 29

2000

Goodman KW. Social and ethical issues. Session on "Prevention trials in autoantibody-positive high risk relatives," Workshop on Future Directions in Prevention of Type 1 Diabetes, National Institute of Diabetes & Kidney Diseases, Miami, Jan. 9.

Moseley R, Goodman KW. Ethical considerations at the end of life, Florida Bar Elder Law Section mid-winter meeting, Amelia Island, Fla., Jan. 28.

Goodman K, Goldaber M. Making choices: Ethical solutions in Alzheimer's care. Alzheimer's Association, Greater Miami Chapter, Miami, Feb. 16.

Goodman, KW. Ethics and elder care, Association of Jewish Aging Services, 40th Annual Conference, Orlando, Feb. 22.

Goodman, KW. Brain death and the public understanding of science. Third International Symposium on Coma and Death, Havana, Feb. 24.

Goodman KW. Digital doctoring: Ethical issues in medical computing. John J. Reilly Center for Science, Technology and Values, Program in History & Philosophy of Science, University of Notre Dame, South Bend, IN, March 27.

Goodman KW. Ethical issues in cancer genetics. Berlex 3rd Annual Genetics Oncology Workshop, Houston, Tex., April 10.

Goodman KW, Jackson MA. Ethical considerations regarding advance directives. 17th Annual Estate and Probate Seminar, Palm Beach County Bar Association, West Palm Beach, May 10.

Goodman KW. Death and confidentiality. Law, Ethics and Death, Florida Bar Health Law Section CLE workshop, Orlando, May 12.

Goodman KW, Frydman G, Temin P. Commentator panelists for keynote panel, Consumer Informatics Supporting Patients as Co-producers of Quality, American Medical Informatics Association Spring Congress, Boston, May 24.

Moseley R, Goodman KW. Use of the Florida Bioethics Network. Florida State Guardianship Association Annual Meeting, Orlando, Aug. 5.

Goodman KW. Ethical issues at the end of life. End-of-Life Care Symposium, Annual Meeting of the Florida Medical Association, Orlando, Sept. 2.

Armstrong D, Goodman K, et al, panelists. Controversies in the Medical, Legal & Ethical Issues of Avoiding Blood Transfusion, University of Miami/Jackson Memorial Medical Center, Miami, Sept. 8.

Goodman KW. Ethics, genomics, computers: How information technology is changing the rules for science and society. 12th International Genome Sequencing and Analysis Conference, The Institute for Genome Research (TIGR), Miami Beach, Sept. 15.

Goodman KW. Security, confidentiality and privacy: Healthcare ethics in the information age, Keynote Presentation, MemorialCare Technology Conference 2000, Long Beach, Calif., Sept. 16

Panelist, Ethics Forum: Genetics. Florida Nurses Association Annual Convention, Miami, Sept. 20.

Goodman KW. Genetics, computing and ethics: Some problems for the next few hundred years. Ethics: Unusually Difficult Challenges in Epidemiology and Human Subjects Research, University of Miami Ethics Programs, Miami, Oct. 12.

Beckwith S., Goodman KW., MacDonald L. Florida Partnership for End-of-Life Care, Law and Ethics at the End of Life, Florida Bioethics Network Fall Conference, Jacksonville, Oct. 19.

Goodman KW. Legal and procedural safeguards in end-of-life decision making. Law and Ethics at the End of Life, Florida Bioethics Network Fall Conference, Jacksonville, Oct. 20.

Goodman KW. Norms and neurology: Ethical issues in intellectual and developmental disability. Mailman Center for Child Development, Friday Seminar Series, University of Miami School of Medicine, Oct. 27.

Gertel A, Goodman K, Moreno J. Biomedical ethics: Gray matters, redux. American Medical Writers Association, 60th Annual Conference, Miami, Nov. 9.

Goodman KW. Ethics and informatics. Genesis Health System Ethics Conference 2000, Bettendorf, Iowa, Nov. 17.

1999

Panelist, "Ethical Issues in Neurogenetics," Miami Project to Cure Paralysis, University of Miami School of Medicine, Feb. 25.

Goodman KW. Introduction to informed consent. American College of Medical Genetics annual clinical genetics meeting, March 20, Miami (Workshop A3, Paradigms for designing informed consent for genetic testing and research. Abstract: *Genetics in Medicine* 1999;1(1):21).

Goodman KW. Ethical issues in cancer genetics. Berlex 3rd Annual Genetics Oncology Workshop, San Diego, Calif., March 24,

Panelist, When Should Exposing Someone to HIV be a Crime? Eighth Annual Florida HIV Conference, Florida AIDS Education and Training Centers Network, Orlando, March 31.

Guest lecturer, Health Information Privacy, Nova Southeastern University Shepard Broad Law Center, Law and Medicine Seminar, Fort Lauderdale, Fla., April 5.

Goodman KW. Why ethics is not a lot of touchy-feely foo-foo: Lessons for patient representatives. Florida Society of Patient Representatives, Orlando, June 11.

Goodman K, panel chair, The Future of Healthcare Ethics, Florida Bioethics Network annual meeting, Fort Lauderdale, June 24.

Goodman K, panelist, Issues in End-of-Life Legislation in Florida, Florida Bioethics Network annual meeting, Fort Lauderdale, June 24.

Goodman K, panel chair, Clinical Advances in Biomedicine, South Florida Hospital Research and Education Foundation, The Future Healthcare System: Technology & Treatment for 2000 & Beyond, North Miami, June 30.

Goodman KW. Ethical and legal issues for the elderly. Jackson Memorial Hospital, The Autumn of Our Lives: Geriatric Health Care, Miami, July 9.

Goodman KW. Bioethics: Health care's two-edged sword. Florida Society for Healthcare Public Relations & Marketing, 33rd Annual Meeting, Orlando, July 14.

Goodman KW. Ethics and epidemiology, Nova Southeastern University, Concepts, Issues and Values in Health Care Education, Fort Lauderdale, July 28.

Goodman KW. Medical Ethics. Third Annual Florida Liability Claims Conference, Orlando, July 29.

Goodman KW. Ethical Considerations in Organ Transplantation. Third Annual Florida Liability Claims Conference, Orlando, July 30.

Goodman KW, moderator, Bioethics and the Law: ERISA and the Challenge of Managed Care, National Association of Women Judges, Miami Beach, Oct. 16,

Goodman KW, panelist, Ethical Decision Making in Managed Care — Unionization and Collective Bargaining, Florida Association of Health Maintenance Organizations, Tampa, Fla., Nov. 18.

Chang BL, Goodman KW, Renner J, Consumers, health informatics and the media, workshop, Annual Symposium of the American Medical Informatics Association, Washington, D.C., Nov. 7.

Jadad AR, Goodman KW, Jones HG et al., Consumer participation in informatics research and development: Ethical, social, methodological and political challenges, panel, Annual Symposium of the American Medical Informatics Association, Washington, D.C., Nov. 9.

Goodman KW. Ethical and social challenges for health computing: Focus on bioinformatics, tutorial, Annual Symposium of the American Medical Informatics Association, Washington, D.C., Nov. 7

Goodman KW. Why ethics matters in medical computing. SUN Users Conference, Miami, Dec. 6.

1998

Goodman KW. Is Diagnosis Desirable in Families with Polycystic Kidney Disease? 25th Annual Pediatric Nephrology Seminar, Miami Beach, Feb. 1.

Goodman KW. Memory and Hope: Ethical Issues in Dementia Care. Third Annual Educational Conference, Alzheimer's Association, Greater Miami Chapter, Davie, Fla., Feb. 25.

Goodman KW. Computers and Medicine: Ethical Considerations and Challenges. American Academy of Dermatology, 56th Annual Meeting, Orlando, Feb. 28.

Goodman KW. Ethical Challenges in Animal Welfare. Laboratory Animal Management Association, mid-year forum, Fort Lauderdale, Fla., April 24.

Goodman KW. Ethical Behavior in Government and Business. Leadership Miami Focus Session, Miami, April. 25.

Goodman KW. Genetics Research (panelist). Interface of Science, Ethics and Law in Human Subjects Research, FDA, OPRR, UM FAMU joint conference, Miami Beach, April 27.

Goodman KW. The Waiver of Informed Consent (panelist). Interface of Science, Ethics and Law in Human Subjects Research, FDA, OPRR, UM FAMU joint conference, Miami Beach, April 28.

Goodman KW. Reimbursement and Compensation of Subjects. Interface of Science, Ethics and Law in Human Subjects Research, FDA, OPRR, UM FAMU joint conference, Miami Beach, April 28.

Goodman KW. Ethics and Risk Management. South Florida Society for Healthcare Risk Management, Miami, May 12.

Goodman KW. The Problem of Advance Instructions (panelist). Problems and Strategies in Implementing Florida Statute 765, University of Florida Program in Medical Ethics, Law and the Humanities, Gainesville, May 14.

Goodman KW. Family Challenges to the Advance Directive: Medical Futility. (panelist). Problems and Strategies in Implementing Florida Statute 765, University of Florida Program in Medical Ethics, Law and the Humanities, Gainesville, May 15.

Goodman KW. Research Ethics. GI Research Conference, University of Miami Division of Gastroenterology, Miami, May 22.

Goodman KW. Ethics and Bioinformatics: Making Sense of Computational Oncology Research. Population Science Meeting, Fox Chase Cancer Center, Philadelphia, May 26.

Goodman KW. Ethical Issues at the Point of Use (panel chair). American Medical Informatics Association, Spring Congress, Philadelphia, May 27.

Goodman KW. Managing Sex Offenders: Public Policy and Ethics. South Florida Evaluation and Treatment Center, Miami, June 10.

Cava A, Goodman KW. Ethics in Business and Government. Greater Miami Chamber of Commerce Goals Conference, Aventura, Fla., June 13.

Goodman KW. Clinical futility. Miami Area Geriatric Education Center, Intensive Geriatric Training, Fort Lauderdale, July 9.

Goodman KW. Facilitator, Health Council of South Florida Annual Planning Retreat, Key West, Fla., Sept. 11.

Goodman KW. What on Earth Does Ethics Have to Do with Malpractice Work? Florida Medical Malpractice Claims Council, Palm Beach, Fla., Sept. 12.

Goodman KW. Life, Death and the Law: Challenges with Advance Directives. Cleveland Clinic Florida, Medical Grand Rounds, Fort Lauderdale, Sept. 16.

Goodman K, panelist, Bioethics and Technology in Corrections. 44th Annual Southern Conference on Corrections, Palm Beach, Fla., Sept. 22.

Goodman KW. Ethics and Arthritis, Florida Chapter, The Arthritis Foundation, Fort Lauderdale, Oct. 17, 1998.

Goodman KW. "Jailhouse Ethics: Good Care for Bad People," Florida Bioethics Network Eighth Annual Conference, Oct. 22, Orlando.

Goodman KW. Ethical Challenges Facing Not-for-Profit Organizations, Miami-Dade Coalition on Aging, Alliance for Aging, Miami, Oct. 30, 1998.

Goodman, KW. "Ethical and Social Challenges for Medical Informatics," Tutorial Session, American Medical Informatics Association Annual Symposium, Orlando, Nov. 7.

Goodman, KW., Workshop Organizer, "Ethics and Informatics: Educational Challenges for the Next Millennium," American Medical Informatics Association Annual Symposium, Orlando, Nov. 8.

Goodman KW. "Ethical Issues in the Use of Animals," VA Medical Center Animal Studies Training Workshop, Miami, Nov. 19.

Goodman K, et al., panelists, "Doctor, Where Are You? Jewish Ethics and the Health Delivery Revolution," The Jewish Theological Seminary, West Palm Beach, Nov. 22.

Goodman KW. Ethics and politics. Greater Miami Chamber of Commerce, Leadership Miami program, Miami, Dec. 5.

Goodman KW. Ethics, evidence and quality. Dade Association for Healthcare Quality, Miami, Dec. 16.

1997

Goodman K, Informed Consent for Clinical, Cosmetic and Research Procedures, Dermatology Seminar, UM Department of Dermatology and Cutaneous Surgery, Feb. 5.

Panel member, Health Care: Right or Privilege, UMSM 14th Annual Student Council Convention, Feb. 6.

Panel member, Right to Die, Organization for Human Rights, UM School of Law, Feb. 12.

Goodman, KW. Meta-analysis: opportunities and challenges, Combined Endocrinology and Diabetes Grand Rounds, UM Department of Medicine, Feb. 27.

O'Connell, M, Goodman KW. Evidence-based medicine, MD/PhD Grand Rounds, Feb. 24, and April 15, 1997.

Goodman, KW. Archived Samples and Bioinformatics: Lessons from the Banked Tissue and Sera Debate. American College of Medical Genetics, Annual Meeting, Fort Lauderdale, March 2.

Goodman, KW. Ethical Issues in International Occupational Health, American College of Occupational and Environmental Medicine, Annual Meeting, Orlando, May 16.

Goodman KW. Progress in ethics: From "Dilemma Fetishism" to genetics and psychiatry. 22nd International Congress on Law and Mental Health, Montreal, June 19-21.

Goodman KW. Computers, patient outcomes and physician profiling. Broward General Medical Center Grand Rounds, Fort Lauderdale, July 10.

Panelist, Prostate Cancer: To Screen or Not to Screen, Third Annual Florida Epidemiology Meeting, Miami Beach, July 25.

Goodman KW. Clients, Computers and Confidentiality, Florida Council on Aging Florida Aging Network Training Conference, St. Petersburg Beach, Fla., Aug. 25.

Goodman, KW. Ethical Challenges Facing Health Care Professionals. South Florida Case Management Network, Miami, Sept. 10.

Panelist, Neuroscience Grand Rounds on Ethical Problems, UM Department of Neurology, Sept. 12, 1997

Goodman, KW. "Ethical Challenges in Minority and Elderly Recruitment." Increasing Participation of Minorities and Older Americans in Clinical Research, UM/Sylvester Comprehensive Cancer Center, Coral Gables, Fla., Sept. 17.

Goodman, KW. "Findings from the American College of Epidemiology Ethics Survey on the Need for Ethics Guidelines for Epidemiologists," Annual Scientific Meeting, American College of Epidemiology, Cambridge, Mass., Sept. 23, 1997.

Goodman, KW. "Alternative Approaches to Clinical Ethics," Florida Bioethics Network, Seventh Annual Conference, Tampa, Oct. 8, 1997.

Goodman, KW. "Ethical and Social Challenges for Medical Informatics," Tutorial Session, American Medical Informatics Association Fall Symposium, Nashville, Oct. 25.

Goodman, KW., Panel Organizer, "Ethical Issues in Internetable Health Care," American Medical Informatics Association Fall Symposium, Nashville, Oct. 28

Goodman, KW. "The Medical Futility Project," Health Council of South Florida, 1997-98 Board of Directors Retreat, Hawk's Cay, Fla., Oct. 31.

Goodman, KW. "Ethical Issues Concerning the Use of Animals." Animal Studies Training Workshop, VA Medical Center, Miami, Nov. 25.

1996

Goodman, K. Panelist, Are Bioethical Questions Creating More Controversy in Medical Care? Florida Medical Association 1996 Media and Medicine Conference, Orlando, Jan. 25.

Goodman, K., and Moseley, R. Medicine, Morals and the Media: Bioethics Issues in Hospital Public Relations and Marketing. Florida Hospital Association, Orlando, Jan. 26.

Holzman, B., Armstrong, A., Goodman, K. Faculty, Pediatric Bioethics Workshop, Masters of Pediatrics conference, University of Miami Department of Pediatrics, Jan. 29.

Goodman, K. Ethical Issues in Forensic Psychology, South Florida Evaluation and Treatment Center, Florida Department of Health and Rehabilitative Services, Miami, Feb. 2.

Goodman, K. Death in the ICU: It's Not What It Used to Be. Miami Teaching Institute, Greater Miami Chapter, American Association of Critical Care Nurses, Miami, Feb. 9.

Goodman, K. Brain Death, Medical Futility and Other Confusing Concepts: Lessons in Moral Fallibility. Second International Symposium on Brain Death, Havana, Feb. 29.

Goodman, K, and Feltman, D. Ethics, Economics and Managed Care. Advances in Geriatrics VIII, Miami Area Geriatric Education Center (MAGEC), Miami, March 30.

Franzblau, M, Brosco, J., and Goodman, K. Ethical Issues in Health Care: Lessons from the History of Medicine. University of Miami School of Medicine, April 15-26.

Goodman, K. Ethical Issues in Neonatal Nursing. Southeast Florida Association of Neonatal Nurses, Hialeah, May 28.

Goodman, K. The Ethics of Scientific Collaboration. Outcomes Research Group, University of Miami School of Medicine, May 29.

Goodman, K. Ethical Issues in Clinical Research: The Role of Trainees, Department of Urology Grand Rounds, University of Miami School of Medicine, May 31.

Goodman, K. Predicting Death: Can We Do it, and Can Computers Help Us? "End of Life Decisions 1996," Baptist Health Systems of South Florida, Sept. 21.

Goodman, K. Risks, Rules and Ratios: Ethically Communicating about Health and Disease, U.S. Centers for Disease Control and Prevention, Atlanta, Sept. 27.

Goodman, K. Advice on Consent: Where Science and Ethics Meet, U.S. Centers for Disease Control and Prevention, Atlanta, Sept. 27

Goodman, K. Computers in Pediatric Diagnosis and Prognosis: Ethical and Social Issues, UMSM Department of Pediatrics Staff Conference, Oct. 15.

Goodman, K. Ethics Committees: Structure, Function, and JCAHO Requirements. Florida Bioethics Network Sixth Annual Conference, Fort Lauderdale, Oct. 23.

Goodman, K. et al. Panel discussion, What Bothers Me about My Ethics Committee? How We Handle Those Problems, Florida Bioethics Network Sixth Annual Conference, Fort Lauderdale, Oct. 24.

Goodman, K. Can Scoring Systems Determine Futility? Florida Bioethics Network Sixth Annual Conference, Fort Lauderdale, Oct. 25.

Goodman, K. Ethical and Social Challenges for Medical Informatics, tutorial, American Medical Informatics Association fall symposium, Washington, D.C., Oct. 26.

Goodman, K. Ethics and Meta-Analysis, UM Outcomes Research Study Group, Dec. 5.

1995

Goodman, K. Why Ethics in Medicine is not Touchy, Feely, Warm or Fuzzy, Association for the Behavioral Sciences and Medical Education (ABSAME), Naples, Fla., Oct. 7, 1995.

Goodman, K. Why Ethics Matters to Psychology and Psychiatry (Especially When We Have All These Legal Guidelines Floating Around), South Florida Evaluation and Treatment Center (HRS), Miami, July 7, 1995.

Goodman, K. Issues in Publication and Authorship, Grass Foundation Fellowship program, Marine Biological Laboratory, Woods Hole, Mass., June 28, 1995.

Goodman, K. Ethics and Epidemiology, New England Epidemiology Institute and Tufts University, Boston, June 26-30, 1995.

Goodman, K. Restructuring the Health Care System and Tips on How to Improve the Visibility and Viability of Education in the Midst of Change, Florida Medical Association, 121st Annual Meeting, Miami Beach, June 1, 1995.

Goodman, K. Bioethics & Pastoral Care, Jackson Memorial Hospital Department of Pastoral Care program, "The Clergy and the Cancer Patient," May 26, 1995.

Goodman, K. Panelist, AIDS and Suicide: Psychiatrists' Role in End-of-Life Decisions, American Psychiatric Association annual meeting, Miami Beach, May 22, 1995.

Goodman, K. Medical Ethics in the Care of the Elderly, Hartford Generalist Physician Initiative Conference, Miami Beach, April 28, 1995.

Goodman, K. On Progress in Law in Ethics, "Health Care Regulation and Reform" course, Prof. M. Farrell, University of Miami School of Law, April 20, 1995.

Goodman, K., Kinzbrunner, N. A Philosopher and a Physician Discuss Assisted Suicide, "Decisions Near the End of Life," Education Development Center and the Hastings Center, Miami, March 24, 1995.

Goodman, K. Ethics of Animal Research, Animal Research Training Session, Veterans Affairs Medical Center, Miami, March 21, 1995.

Goodman, K. et al. Moderators, Legislative Panel: "Reshaping Health Care in the '90s and Beyond: A Legislative Symposium on Health Care Reform," sponsored by the Health Council of South Florida, Miami Panelists: Rep. John F. Cosgrove, chair, House Insurance Committee; State Sen. Alberto Gutman, chair, Senate Health Care Committee; Rep. J. Alex Villalobos, chair, Dade County Legislative Delegation; Miami, March 2, 1995.

Goodman, K., Needell, M. Ethics and Risk Management, Parkway Regional Medical Center, North Miami Beach, March 2, 1995.

Goodman, K.. Moot Court judge, University of Miami School of Law, Feb. 25, 1995.

Holzman B, Goodman K, Armstrong D. Pediatric bioethics. UM Department of Pediatrics, "Masters of Pediatrics," Miami, Jan. 22.

Goodman K. When enough is enough: Rationing, futility and assisted suicide. Leadership Miami, "Our Community's Health: Everyone's Business," Miami, Jan. 21.

Goodman K. Ethical considerations for policies dealing with drug seekers, American College of Emergency Physicians, State Chapter of California, "Emergency Medicine at the Ahwahnee," Yosemite, Calif., Jan 14, 1995.

1994

Goodman, K. Ethical Issues in Correctional Health Care, Florida Department of Corrections Office of Health Services, 1994 Workshop, Daytona Beach, Fla., Nov. 16, 1994.

Goodman, K. Ethics, Computers and Epidemiology, Harvard University School of Public Health, Department of Epidemiology, Cambridge, Mass., Oct. 12.

Goodman K. Problems and solutions in publication and authorship. Schepens Eye Research Institute, Harvard Medical School, Cambridge, Mass., Oct. 11.

Goodman K. Ethics and computing in orthopaedics, UM Department of Orthopaedics and Rehabilitation Grand Rounds, Miami, Sept. 29.

Goodman K. Foundations of medical ethics: History, theory and principles of end-of-life issues, Florida Bioethics Network Annual Conference, Orlando, Sept. 21.

Goodman, K. Ethical Issues in Caring for the Elderly: Advance Directives and Decisions in the Absence of Directives, Miami Area Geriatric Education Center, geriatric training program, Miami, May 25; repeated Aug. 31.

Labadie, G., Goodman, K. Ethical Issues in AIDS: Confidentiality and Teaching Perspectives, University of Miami School of Nursing, HIV in the Nursing Curriculum conference, May 20, 1994.

Goodman, K. Computers, Medical Decision-making and Confidentiality, presentation to University of Florida College of Medicine (Shands Hospital Ethics Committee Rounds), Gainesville, Fla., April 8, 1994.

Goodman, K. (Panel chair) Issues Brought to the IRB on HIV/AIDS Research and Confidentiality Issues, Society of Research Administrators, South Florida Chapter, "Outlook '94--A Symposium on AIDS Prevention," VAMC-Miami, March 16, 1994.

Goodman, K. Ethical Issues in Health Care Reform: The Lessons from Florida, presented to Florida Medical Association, "Spring Break for CME," Palm Beach Gardens, Florida, March 3, 1994.

Goodman K. Computer assisted decision making in the ED, American College of Emergency Physicians, State Chapter of California, "Emergency Medicine at the Ahwahnee," Yosemite, Calif., Jan 13, 1994.

1993

Goodman, K. Uncertainty and ethics in medical computing, Second Annual Computers in Health Care Conference, Delaware State Hospital, New Castle, Delaware, Nov. 3, 1993.

Goodman, K. Toward a Unified Code of Ethics in Epidemiology, 26th annual meeting of the Society for Epidemiologic Research, Keystone, Colo., June 17, 1993.

Goodman, K. Major Uses of Computerized Diagnostic Systems and the Ethical Questions they Raise. Annual meeting of the Florida Medical Association, Miami Beach, May 8, 1993.

Goodman, K. Ethical Issues in Endocrinology, University of Miami Department of Medicine combined Endocrinology and Metabolism Grand Rounds, April 15, 1993.

1992

Pennell, J.P., Goodman, K. Should Sovereign Immunity be Extended to Private Physicians? Presentation to Society for Health and Human Values annual meeting, Memphis, November 1992.

Goodman K. Cultural relativism, truth-telling and informed consent. Transcultural Nursing in Retrospect and Prospect, 18th Annual Transcultural Nursing Society Conference, Miami, Oct. 23, 1992.

Goodman, K. Ethical Correlates of Physician-Patient Conflict, University of Miami Department of Obstetrics-Gynecology Grand Rounds, Sept. 23, 1992.

Goodman, K. Why Abortion Might Be Wrong But Should Be Legal, University of Miami Department of Philosophy / Friends of Philosophy series, Feb. 26, 1992.

Goodman, K. Ethical Issues in Computational Meta-Analysis, presented to American Association for the Advancement of Science annual meeting, Chicago, Feb. 7, 1992.

Goodman, K. Bioethicists, Journalists and Public Policy: The Philosopher Cops, presented to National Conference on Ethics & the Professions, Gainesville, Fla., Jan. 31, 1992.

Goodman, K. Case-Based Ethical Analysis in Dermatology, University of Miami Department of Dermatology Grand Rounds, Jan. 15, 1992.

1990

Goodman, K. Ethics and research in publishing, University of Pittsburgh College of Medicine Student Publishing Workshop, Graduate School of Public Health, Nov. 27, 1990.

Goodman, K. Ethical Issues in Medicine and Communication, presented to the University of Pittsburgh College of Medicine Center for Medical Ethics, Nov. 8, 1990.

Goodman, K. Doing Good and Doing Well: Questions of Ethics and Economics, presented to Hospital Council of Western Pennsylvania, Erie, Oct. 4, 1990.

Goodman, K., Nirenburg S. To Save the Semantic Phenomena: Machine Translation and Interlingua Texts, presented at the Fifth Annual Computers and Philosophy Conference, Stanford University, Palo Alto, Calif., August 9, 1990.

Goodman, K. Communicating Change: Experts and Progress in Medicine, Spring Conference of the Society for Health and Human Values, Hershey, Pennsylvania, April 20, 1990.

Goodman, K. Ethical, Social, Legal and Economic Responsibilities in Medical Rehabilitation, Panel discussion with Arnold S. Relman, Editor, *New England Journal of Medicine*, sponsored by Harmarville Rehabilitation Center, Pittsburgh, March 20, 1990.

1989

Goodman, K., invited participant, Professional Ethics in Higher Education: Methods, Theories, Practices, The Poynter Center for the Study of Ethics and American Institutions; Bloomington, Ind. Sponsored by the Harvard Program in Ethics and the Professions, Indiana University-Bloomington CBiomedicalhancellor, The Lilly Endowment and the Poynter Center, July 5-8, 1989.

Goodman, K. Kant's Categories as Semantic Primitives, 34th Annual Conference of the International Linguistic Association, New York, April 18, 1989.

1987

Goodman, K. Theoretical terms, Florida Philosophical Association 33rd Annual Meeting, St. Petersburg, Nov. 14, 1987. FPA award for best graduate student paper.

VI. TEACHING

28. Teaching awards received

29. Teaching specialization:

2022

"Ethics in Public Health," University of Miami Miller School of Medicine, spring

2021

"Ethics in Public Health," University of Miami Miller School of Medicine, spring

"Research Ethics," University of Miami Miller School of Medicine, spring; with others,

2020

"Research Ethics," University of Miami Miller School of Medicine, spring; with others,

2019

"Professional Ethics, Law and Medicine," University of Miami School of Medicine; winter, spring.

Hospitals Health Care Services and Access: An Interdisciplinary Inquiry, University of Miami School of Law; spring. One of many faculty members.

"Research Ethics," University of Miami College of Arts and Sciences, College of Engineering, etc.; winter.

2018

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

Hospitals Health Care Services and Access: An Interdisciplinary Inquiry, University of Miami School of Law, spring 2018. One of many faculty members.

"Research Ethics," University of Miami School of Medicine and College of Arts and Sciences (varia).

"Research Ethics," University of Miami School of Medicine (autumn).

2017

CTI-603 Research Ethics (CTSI MA program, with Joanna Johnson) (spring)

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

"Research Ethics," University of Miami school of Medicine and College of Arts and Sciences (varia).

"Research Ethics," University of Miami School of Medicine, (autumn) (CTI-603, ie, special CTSI course).JohJoh

2016

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

2015

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

2014

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

2013

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

"The Idea of the Hospital," University of Miami School of Law, spring 2013. One of many faculty members.

2012

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

"The Idea of the Hospital," University of Miami School of Law, spring 2012. One of many faculty members.

2011

"Knowledge and Evidence in Medicine," University of Miami Department of Philosophy (spring)

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

"The Idea of the Hospital," University of Miami School of Law, winter 2011. One of many faculty members.

2010

"Bioethics," University of Miami Department of Philosophy (spring)

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

2009

"Bioethics," University of Miami Department of Philosophy (spring)

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter).

"Clinical Ethics" (with D. Buckner), University of Miami Department of Medicine / medicine clerkship (all semesters).

2008

"Bioethics," University of Miami Department of Philosophy (spring)

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter).

"Clinical Ethics" (with D. Buckner), University of Miami Department of Medicine / medicine clerkship (all semesters).

2007

“Social and Ethical Issues in Computing,” University of Miami Departments of Computer Science and Philosophy (spring).

“Research Ethics,” University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

“Professional Ethics, Law and Medicine,” University of Miami School of Medicine (winter).

“Clinical Ethics” (with D. Buckner), University of Miami Department of Medicine / medicine clerkship (all semesters).

2006

“Bioethics,” University of Miami Department of Philosophy (spring)

“Research Ethics,” University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

“Professional Ethics, Law and Medicine,” University of Miami School of Medicine (winter).

Other: “Patient Safety Course,” University of Miami School of Medicine, faculty member, “Error Disclosure and Patient Centeredness” lecture.

“Clinical Ethics” (with J.P. Pennell), University of Miami Department of Medicine / medicine clerkship (all semesters).

2005

“Bioethics,” University of Miami Department of Philosophy (fall).

“Research Ethics,” University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

“Professional Ethics, Law and Medicine,” University of Miami School of Medicine (winter).

“Clinical Ethics” (with J.P. Pennell), University of Miami Department of Medicine / medicine clerkship (all semesters).

2004

“Environmental Ethics,” University of Miami Department of Philosophy (spring).

“Research Ethics,” University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

“Professional Ethics, Law and Medicine,” University of Miami School of Medicine (winter).

“Clinical Ethics” (with J.P. Pennell), University of Miami Department of Medicine / medicine clerkship (all semesters).

2003

“Bioethics,” University of Miami Department of Philosophy (spring).

“International Health Policy and Ethics” (INS 572 with S. Porcelain), University of Miami School of International Studies (spring).

“Professional Ethics, Law and Medicine,” University of Miami School of Medicine (winter).

"Research Ethics," University of Miami Schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Clinical Ethics" (with J.P. Pennell), University of Miami Department of Medicine / medicine clerkship (all semesters).

2002

"Professional Ethics," University of Miami Department of Philosophy (spring).

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Medical Ethics," University of Miami School of Medicine, co-design and coordinate new ethics curriculum.

"Clinical Ethics" (with J.P. Pennell), University of Miami Department of Medicine / medicine clerkship (all semesters).

2001

"Bioethics," University of Miami Department of Philosophy (spring)

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Clinical Ethics" (with J.P. Pennell), University of Miami Department of Medicine / medicine clerkship (all semesters).

1999

"Ethics, Epidemiology and Public Health," University of Miami School of Medicine, Department of Epidemiology and Public Health (spring).

"Bioethics," University of Miami Department of Philosophy (spring)

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Clinical Ethics" (with J.P. Pennell), University of Miami Department of Medicine / medicine clerkship (all semesters).

1998

"Ethics, Epidemiology and Public Health," University of Miami School of Medicine, Department of Epidemiology and Public Health (spring).

"International Health Policy and Ethics" (with S. Porcelain), University of Miami School of International Studies (spring).

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Clinical Ethics" (with J.P. Pennell and M.H. Needell), University of Miami Department of Medicine / medicine clerkship (all semesters).

1997

"Bioethics," University of Miami Department of Philosophy (spring)

"International Health Policy and Ethics" (with S. Porcelain), University of Miami Graduate School of International Studies (spring).

"Medical Informatics" (with others), University of Miami departments of Radiology and Electrical Engineering (spring).

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Ethics and Epidemiology," New England Epidemiology Institute and Tufts University, Medford, MA (summer).

"Clinical Ethics" (with J.P. Pennell and M.H. Needell), University of Miami Department of Medicine / medicine clerkship (all semesters).

"Ethical Values in Health Care: Lessons from the Nazi Era," UM School of Medicine Senior Elective, with Drs. Michael Franzblau and Jeffrey Brosco.

1996

"Ethics and Epidemiology," University of Miami School of Medicine, Department of Epidemiology and Public Health (fall).

Dissertation Seminar, University of Miami Graduate School of International Studies (spring).

"Ethics and Epidemiology," New England Epidemiology Institute and Tufts University, Medford, MA (summer).

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Clinical Ethics" (with J.P. Pennell and M.H. Needell), University of Miami Department of Medicine / medicine clerkship (all semesters).

1995

"Health Care Reform: Policy, Structure, Ethics" University of Miami School of Nursing (fall and spring).

"Ethics and Epidemiology," University of Miami School of Medicine, Department of Epidemiology and Public Health (fall).

"Ethics and Epidemiology," New England Epidemiology Institute and Tufts University, Medford, MA (summer).

"International Health Policy and Ethics" (with S. Porcelain), University of Miami Graduate School of International Studies (spring).

"Professional Ethics," University of Miami Department of Philosophy (spring).

"Clinical Ethics" (with J.P. Pennell and M.H. Needell), University of Miami Department of Medicine / medicine clerkship (all semesters).

"Research Ethics," University of Miami Schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

1994

"Health Care Reform: Policy, Structure, Ethics" University of Miami School of Nursing (spring).

“Computers, Ethics and Society,” University of Miami Freshman Seminar series (fall).

“Clinical Ethics” (with J.P. Pennell and M.H. Needell), University of Miami School of Medicine, Department of Medicine / medicine clerkship (all semesters).

“Research Ethics,” University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

1993

“Health Care Organization, Policy and Ethics,” University of Miami Freshman Seminar series (fall).

“Clinical Ethics” (with J.P. Pennell and M.H. Needell), University of Miami School of Medicine, Department of Medicine (all semesters).

“Research Ethics,” University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

1992

“Clinical Ethics,” (with others) University of Miami School of Medicine, Department of Medicine; third-year medical students on Medicine clerkship.

1991

“Professional Writing,” Duquesne University Department of Communication (spring).

“Business Ethics,” Duquesne University School of Business and Administration (summer).

1990

“Professional Writing,” Duquesne University Department of Communication (fall).

1989

“Professional Writing,” Duquesne University Department of Communication (fall).

1988

“Professional Writing,” Duquesne University Department of Communication (fall).

1985

“Introduction to Logic,” University of Miami College of Arts and Sciences, Department of Philosophy (fall, spring)

1984

“Introduction to Logic,” University of Miami College of Arts and Sciences, Department of Philosophy (fall)

30. Thesis and dissertation advising/post-doctoral student supervision:

- Heleana Theixos, doctoral dissertation, “[Moral Injury in Contemporary Ethics: The Application of a Socratic Idea](#),” Philosophy, 2014-2016, committee chair
- John Pinkston, doctoral dissertation, “[Evidence And Hypothesis In Clinical Medical Science](#),” Philosophy, 2014-2016, committee member
- Wanda Castro, doctoral dissertation, “The feminization of HIV/AIDS in the Republic of South Africa: Examining the influence of socio-economic, political and cultural determinants, Epidemiology, 2006-2011; committee member
- Matthew Schuh, doctoral candidate, Philosophy, 2008; committee member

- Jeremy Morris, doctoral candidate, Philosophy, 2006-2007; committee member
- Nenad Popovic, doctoral candidate, Philosophy, 2005-2006; committee member
- Rajdeep Singh Jolly, Decisional autonomy and Indian sex selection, *magna cum laude* candidate, UM College of Arts & Sciences/Philosophy, 2003; thesis co-adviser
- Sophia S. Chutkan, master of science thesis, Nutrition and Dietetics, Florida International University, 2002-2003; committee member
- Marguerite Purnell, doctoral candidate, Nursing, 2001-2003; committee member
- Maritza Flores, doctoral dissertation, "[The application of the biomedical model and computer technology in decision-making mental care diagnosis and treatment](#)," Sociology, 2001-2003; committee member
- Ruben Rabinsky, NIEHS postdoc, 2001-2003; committee member
- Yvette Pearson, doctoral candidate, Philosophy, 2001-2002; committee member

VII. SERVICE

31. University committee and administrative responsibilities:

Member, UHealth End-of-Life Taskforce, 2020-present

Member, Covid-19 Vaccine Allocation Committee, 2020-

Member, Scientific Misconduct Committee Pool, 2018-2020.

Member, Professional Activity Review Committee (CN), 2010-present; manager/coordinator, 2016-present.

Examiner, BIOT 6006, Bioethics, Biosafety and Intellectual Property Rights in Biotechnology, University of the West Indies, St. Augustine Campus, Trinidad and Tobago, 2016-2018.

Member, Academy of Medical Educators, 2012-present.

Member, UM College of Arts and Sciences graduate faculty, 2012-present.

Member, University of Miami Center for Computational Science, 2011-present.

Member, University of Miami Conflict of Interest Committee, 2010-present.

Member, University of Miami Task Force Committee, Civic Engagement Project, Office of the Senior Vice Provost, 2010-present.

Member, University of Miami Embryonic Stem Cell Research Oversight Committee, 2009-2011.

Member, Faculty Steering Committee, University of Miami Jay Weiss Center for Social Medicine and Health Equity, 2007-present.

Member, University of Miami Medical Group Clinical Operations committee, 2006-2009.

Member, University of Miami Faculty Senate Hearing Panel, 2004-2014.

Member, Jackson Memorial Hospital/UM HIPAA Steering Committee, 2001-2005.

Member, Responsible Conduct of Research Educational Initiative Committee, 2001-2005.

Member, University of Miami core faculty for Human Subjects Protection Seminars, 2001-present

Member, University of Miami Advisory Group for Education in Human Subjects Protections, 2001-2005.

Faculty Advisor, Ethics Society, UM undergraduate service organization, 1994-present.

Member, Bioethics Committee, University of Miami / Jackson Memorial Hospital, 1992-Present. Chair as of July 2007.

Member, Pediatric Bioethics Committee, University of Miami / Jackson Memorial Hospital, 1992-Present.

Member, Jackson Memorial Hospital Transplant Center, Transplant Emergency Panel, November 2008-Present.

Member, Human Studies Subcommittee (IRB), Veterans Affairs Medical Center, Miami, 1992-2001.

Member, Ethics Committee, University of Miami Hospitals and Clinics/Sylvester Comprehensive Cancer Center, 1996-Present; vice chair, 2000-present.

Member, Fetal Board Registry, University of Miami Department of Obstetrics and Gynecology, 1993-1999.

Member, Medical Sciences Subcommittee for the Protection of Human Subjects (IRB), University of Miami/Jackson Memorial Hospital, 1994-2000; alternate, 2000-2003.

Director, Clinical and Research Ethics Education, University of Miami Hospital and Clinics / Sylvester Comprehensive Cancer Center, 1994-present.

Member, Steering Committee, University of Miami Medical Informatics Programs, 1995-1998.

Member, Steering Committee, Outcomes Research Group, 1996-1998.

Preceptor, Clinical Skills Program, University of Miami Department of Medicine, 1992-2000.

Member, Clinical Pastoral Education Professional Advisory Group, Jackson Memorial Hospital, 1993-Present.

Member, Animal Studies Subcommittee, Veterans Affairs Medical Center, Miami, 1994-Present.

Member, Animal Studies Subcommittee, University of Miami, 1994-Present.

Member, Computers in Medical Education committee for LCME accreditation, 1994.

Member, Information Systems Ethics Committee, Jackson Memorial Hospital, 1994-1996.

31a. Other Misc. UM/JMH/VA Contributions

2022

Goodman KW. Big Data, Artificial Intelligence and Privacy in the 21st Century. UHealth Compliance, International Data Privacy Day, January 28.

Goodman KE. Ethics, Research and Learning Health Care Systems. Sylvester Comprehensive Cancer Center, University of Miami Miller School of Medicine, March 23.

2021

Goodman KW, moderator, Theological Perspectives on Organ Donation, Multifaith Council, University of Miami, March 11.

Del Rio C, Goodman KW, Ross LF. A National Conversation: Should Covid-19 Vaccines Be Mandatory on College Campuses? With UM President Julio Frenk, Miller School of Medicine Dean Henri Ford and Department of Medicine Chair Roy Weiss. March 17, University of Miami Webinar,

2018

Goodman KW. Futility, computational decision support and ethics: Why the future of surgery is not what it used to be. University of Miami Miller School of Medicine Department of Surgery, Grand Rounds, March 29.

Goodman KW. Keynote speech. MD/MPH Rose Ceremony, May 25.

2017

Goodman K. Ethics introduction. Compliance and Ethics Week training, November 7, 8 and 9, University of Miami Medical, Marine and Gables campuses.

2015

Goodman KW. Guest speaker. MD/MPH Class of 2018 Anatomy Rose Ceremony, UM Miller School of Medicine, May 18.

Goodman KW. Ethics and leadership. Leadership Development in Neurodevelopmental Disabilities (LEND) Project, UM Miller School of Medicine, Department of Pediatrics, May 15.

2014

Goodman KW. Ethical issues in academia. Faculty Roles and Responsibilities, University of Miami School of Nursing and Health Studies, January 8.

2013

Goodman KW. Access to health care: how ethics should influence public policy. Friends of Philosophy, UM Department of Philosophy, February 13.

Goodman KW. Strategic data sharing by ordinary people: Translational science's reliance on trust and reciprocity. Miami CTSI Translational Science Institute Seminar Series, November 20.

Goodman KW. Ethics, translational science and the IRB: The future is (still) not what it used to be. IRB Grand Rounds, University of Miami, December 10.

2012

Panelist, Miami Council for International Visitors and U.S. Department of State, delegation from Zambia on media freedom, licensing of journalists, etc. UM School of Communication, March 8.

Moderator, HealthCanes, presidential debate, October 1.

2011

Goodman KW. Ethics and translational research: New challenges in genetics, public policy and health information technology. Miami Clinical and Translational Science Seminar Series, UM Miller School of Medicine, November 9.

Goodman KW. Conflicts of interest. UM Miller School of Medicine, Teaching Professionalism Series, March 7.

Goodman KW Ethics in cancer care. Surgical oncology fellows, SCCC, June 8.

2010

Goodman KW. Clinical ethics. UM Division of Gastroenterology, January 28

Goodman KW. Wireless pediatrics: Ethics and the role of personal health records. Clinical Research Forums in Pediatrics, UM Division of Pediatric Clinical Research, March 3.

2009

Panelist, of 5. Brands, cultures and globalization. University of Miami School of Business Global Business Forum, January 16.

Goodman KW. Pediatric contributions to biobanks. Clinical Research Forums in Pediatrics, Division of Pediatric Clinical Research, UM Miller School of Medicine, January 28.

Goodman KW. Ethics and Information Technology. Department of Electrical and Computer Engineering Seminar Series, University of Miami College of Engineering, February 4.

Panelist, of 5. Academic Integrity Forum. University of Miami Undergraduate Honor Council, April 15.

Special seminar for Kenyan and other journalists specializing in HIV and medical reporting, on ethics and science writing, UM School of Communication, April 29.

Goodman KW. Stanford Food for Thought Dinner Series, Stanford Residential College, Nov. 9.

Goodman KW. Awkward research: sects, sex and drugs. UM Human Subjects Protection Seminar, Nov. 10.

2008

Goodman KW. Clinical ethics. UM Division of Gastroenterology, Jan. 24.

Goodman KW, Wilkinson JD, Pericak-Vance M. Ethics and genomics panel. 34th Eastern-Atlantic Student Research Forum, UM Miller School of Medicine, Feb. 29.

Goodman KW. Digital genetics and the future of pediatrics: The role of ethics. UM Department of Pediatrics Clinical Research Forum, March 5.

Panelist, of 5. Global Climate Change: Your Health. (National Public Health Week activity.) UM Department of Epidemiology and Public Health, April 7.

Panelist, of 4. Climate change projections: Communicating uncertainty without losing the message. Rosenstiel School of Marine and Atmospheric Sciences, May 8.

Goodman KW. Stem cell research: Issues in ethics, science and public policy. Osher Lifelong Learning Institute, September 24.

2007

Panel discussion on codes of ethics in public relations. With International Public Relations Association President Philip Sheppard; Jay Black, Poynter Jamison Media Ethics Chair, University of South Florida-St. Petersburg; and Roger Bolton, President of the Arthur W. Page Society. Feb. 20, UM School of Communication.

Goodman KW. Moral responsibility of Holocaust/Legacy Project survivors, JUS421 (M. Sokoloff), April 12.

Panel, Academic Integrity, with Anita Cava, co-director, UM Ethics Programs, and Katie Meier, UM women's basketball coach. Undergraduate Honor Council, Academic Integrity Week, April 17.

Goodman KW. Conflict and consent: Managing disclosure in human subjects research. UM HSRO Human Subjects Research Symposium, May 11.

Goodman KW. Clinical and research ethics. Core Curriculum for Oncology Fellows. Sylvester Comprehensive Cancer Center, Aug. 7.

Cava A, Goodman KW. Community academic expectations. Graduate Student Orientation, Coral Gables, Aug. 16.

Goodman KW. STRIVE student group leadership facilitator, Coral Gables, Oct. 7.

Goodman KW. Ethics and leadership. Freshmen Leadership Academy, Butler Center for Volunteer Service & Leadership Development, Coral Gables, Oct. 15.

2006

Presentation to International Commission on Holocaust Era Insurance Claims (ICHEIC) Service Corps, Miller Center for Contemporary Jewish Studies, April 10.

Presentation to Department of English, Prof. Joanna Johnson, composition.

2005

Goodman KW. Clinical ethics. UM Division of Gastroenterology, Jan. 27.

Goodman KW. Ethics in plastic and reconstructive surgery, UM Department of Surgery, Division of Plastic and Reconstructive Surgery, May 18.

Goodman KW. Error disclosure and patient centeredness. UM Department of Anesthesiology, June 7.

Goodman KW. Research or surveillance? The case of bioterror preparedness. UM Human Subjects Research Forum, August 30.

Goodman KW. The role of ethics in Sponsored Programs. UM Sponsored Programs Education Center, Dec. 15.

2004

Goodman KW. Clinical ethics. UM Division of Gastroenterology, Jan. 22

Goodman KW. The Terri Schiavo tragedy and the use of ethics committees. Ryder Trauma Center TICU nurses, Feb. 10.

Goodman KW. What IRBs need to know about evidence-based practice. UM Human Subjects Research Forum, March 30.

Goodman KW, panelist, Ethics, Reporting and Politics, UM School of Communication and South Florida chapter, Society of Professional Journalists, UMSoC, April 27.

Goodman KW. Questions of ethics. Atlanta Hurricane and Alumni Club, Atlanta, May 5.

Goodman KW. Ethical issues in HIV/AIDS. Visiting speaker, AIDS as a Public Health Issue (EPH583), Department of Epidemiology and Public Health. July 12

Goodman KW. Some ethical issues in hematology/oncology. SCCC didactic conference, July 14.

Goodman KW Research ethics and integrity. UM Department of Dermatology & Cutaneous Surgery, Aug. 27.

Goodman KW. Think about it, talk about it: A discussion on ethics. UM Honor Council, Nov. 17.

Goodman KW. Bioethics and nursing practice. UM Professional Development and Training Office, Dec. 16.

2003

Goodman KW. Ethics and education research II. UM School of Education, Center for Research, January 29.

Panelist. Oceans and Human Health: Risks and remedies from the sea, Town Meeting, National Institute for Environmental Health Sciences and UM Rosenstiel School of Marine and Atmospheric Sciences, Key Biscayne, Feb. 27.

Goodman KW. Foundations of ethics. UM Department of Orthopaedics and Rehabilitation, residents' rounds, March 20.

Panelist. Artificial Intelligence: Ambition and Ethics. UM Solutions and Ethics Society student groups. March 27.

Goodman KW. Do-not-resuscitate orders – and issues. Sylvester Comprehensive Cancer Center nursing staff, April 29.

Goodman KW. Legal issues in end-of-life care, Sylvester Comprehensive Cancer Center EPEC series, June 24.

Goodman KW. Ethics and evidence-based practice. VAMC Miami Medical Center, Research Committee for Nursing, An Evidence-Based Practice, Dec. 4

2002

Panelist, Solutions 2nd Annual Interdisciplinary Symposium, "Science: The Double-Edged Sword," with Luis Glaser, Joyce Schuld, and David Wilson, with Asma Uddin moderating, March 2.

Goodman K, Making sense of consent: Readability, comprehension and the consent process. Office of Research IRB human subject protection/IRB series, March 26.

Goodman K, Evidence-based practice and human subjects research: Oh, great: More stuff for IRBs to have to worry about. Office of Research IRB human subject protection/IRB series, April 9.

Goodman K. Death and dying. Department of Surgery, Division of Trauma/Surgical Critical Care, April 26.

Goodman K. Discussant, "Local growth coalitions, environmental groups and air pollution," by George Gonzalez, American Politics Research Workshop, UM Political Science Department, May 15.

Goodman K. Ethics-schmethics – or practical strategies for IRB review? UM IRB "A," June 17; "B," Aug. 5.

Goodman K. Intro to ethics. Research in Ecology 2002, a UM-Miami-Dade County Public Schools program, under a Howard Hughes Medical Institute grant, Aug. 1.

Goodman K. Death, dying and ethics in pediatrics, UM/JMH Pediatric Noon Conference, Aug. 5.

Goodman K. Questions of ethics, The Audrey R. Finkelstein Experience, Alumni Week, Oct. 11.

Goodman K. What HIPAA will mean for IRBs and researchers. VAMC Miami, Research: Stimulus for Change, Nov. 8.

Sandoval C, Goodman K. Physician-assisted suicide, EPEC Series, UMHC/SCCC, Dec. 17.

2001

Panelist, "En/gendering Sex, Session III: Testing women: Sex and gender in the lab," Solutions student group, April 11.

Goodman KW. Stem cells: Ethical, legal and policy issues. UM Institute for Retired Professionals, Oct. 4.

Goodman KW. End-of-life ethical issues. Jackson Memorial Hospital Clinical Pastoral Education Program, Nov. 13.

Goodman KW. Ethical issues in use of animal models in surgical procedures. VAMC Animal Studies Training Workshop, Nov. 29.

Panelist, "Ethical dimensions of the post-September 11 milieu," UMSM Council on Honorable and Professional Conduct, Dec. 11.

Goodman KW. Policy, justice and international studies: Why ethics matters and why you should care, commencement address, UM School of International Studies, Dec. 13.

2000

Goodman K. Ethics: Why it matters, what it's good for and why you should care. Family Weekend 2000, Department of Student Life, Coral Gables, Oct. 6.

Panelist, "Animal Rights," Humans Helping Animals student group, Coral Gables, Nov. 15.

32. Community activities:

2021

Goodman KW. Guardianship in Residential and Social Settings: Ethical Challenges. Florida State Guardianship Program, Annual Ethics Symposium, April 16.

Godman KW, et al. COVID-19 Vaccine: Issues in Development and Distribution, Women's Healthcare Executive Network of South Florida, Videoconference panel, March 11.

Goodman KW. Interviewer of director and lead actor, *In the Name of the Daughter*, Miami Jewish Film Festival, March 4.

2019

Goodman KW. Pediatric consent for adult-onset genetic malady testing: ethics, education and expertise. South Florida Clinical Genetics Group, Hollywood Memorial Hospital, May 22.

2013

Goodman KW. What would you do? Everyday ethical dilemmas. JFK Medical Center, Challenges for the Hospital Ethics Committee, Atlantis, Florida, October 18.

Goodman KW. DNR vs. AND. Vitas Hospice Corp. Fort Lauderdale, October 18.

2012

Goodman KW. Advance directives and the Florida journey. Integrating Advance Directives, Mercy Hospital, Miami, October 27.

Goodman KW. Dying is not what it used to be: Ethics, technology and the role of the courts. Dade County Bar Association Probate and Guardianship Committee, December 6, Miami.

2010

Goodman KW. Moderator, ethics discussion following screening of *For My Father* at Miami Jewish Film Festival, Coral Gables, Fla., Jan. 17.

Goodman KW. Professionalism and the law for psychologists. Miami Area Geriatric Education Center, Miami, April 16.

Goodman KW. Ethics, science and society: New challenges for the 21st century. Miami Science Museum, Senior Summer Science Series, July 21.

Giles GJ, Goodman KW, Heberer P. Bioethical Responsibilities in the 21st Century, Deadly Medicine in the Nazi Era, U.S. Holocaust Memorial Museum, Boca Raton Regional Hospital, November 4.

2009

Goodman KW. Ponencia: Posibilidades de desarrollo de la bioética en el Estado de la Florida. New Professions Technical Institute, Miami, February 13. (Venezuelan community activity)

Goodman KW. Democracy, Taxes and Government Integrity: Why this Ethics Stuff Really Matters, City of Coral Gables, Boards and Committees Seminar, October 2.

2008

Goodman KW, Participant, Career Day, Feb. 13, and Contemporary Issues in Science, MAST Academy, Miami-Dade County Public Schools, Feb. 20.

Centorino J, Goodman KW, Myers R. Ethics, civility and effective penalties (panel discussion). League of Women Voters, Miami, March 26.

Goodman KW. Eugenics. Baptist Health South Florida, Baptist Hospital, Miami, August 27.

Goodman KW. Practical ethics, vulnerable populations and public policy: Opportunities and obligations. Guardian Association of Pinellas County, St. Petersburg, September 19.

Goodman KW. Access, justice and moral responsibility: Ethical challenges in health care reform. Public Field Hearings on the Health Care Crisis, Rep. John Conyers, chair, Miami, September 20.

2007

Goodman KW. Speaker, Riviera Ladies Day Luncheon, Riviera Country Club, Coral Gables, March 15.

Goodman KW. Scholar in Residence, Temple Beth Ahm Israel, Cooper City, March 16-17.

Goodman KW. Ethics, boundaries and mental health social work. Miami-Dade Area Health Education Center, Miami, March 21.

Goodman KW. Facilitator, "Guardianship Ethics" and "Sex in Nursing Homes: Managing Questionable Capacity and the Desire for Physical Intimacy," Academy of Florida Elder Law Attorneys "Elder Concert," Ft. Lauderdale, March 23.

Goodman KW. Ethics and employee assistance programs. Employee Assistance Association Professionals, Annual Conference, South Florida Chapter, Fort Lauderdale, March 30.

Goodman KW. Who owns life? Genetic research: Ethical perspectives. Broward Region of Hadassah and U.S. Department of Energy, Fort Lauderdale, June 7.

2006

Goodman KW. Keynote presentation, Science National Honor Society Induction Ceremony, Miami-Dade Chapter, Barbara Goleman Senior High, Feb. 3.

Goodman KW. Ethical considerations in human subjects research. South Florida Human Subject Research Benchmarking Network, Hollywood, March 8.

Goodman KW. Ethics and evidence-based practice. "Conversations in Ethics," Baptist Health South Florida, South Miami Hospital, June 28.

Goodman KW, moderator, Miami-Dade County Commission District 8 candidates' debate, sponsored by the Urban Environment League, August 7.

Goodman KW, de Velasco R. Ethics and pandemic preparedness. Temple Judea Yom Kippur Seminar, Coral Gables, Oct. 2.

2005

Goodman KW. Enough already with the death and dying: New challenges in elder care. Keynote presentation, 15th Annual Board of Directors Installation & Awards Luncheon, Alliance for Aging, Inc., Miami, January 13.

Goodman KW. Bioethics: Foundations and fundamentals. Baptist Health System, Homestead Hospital, March 18.

Goodman KW. Panelist, What would I have done? The obligation to save a life. Miami Jewish Film Festival, March 20.

Goodman KW. Presenter, Exemplary Participation in the Science Symposium, MAST Academy, Miami-Dade County Public Schools, March 30.

Goodman KW. Ethical considerations in education. Barry University School of Nursing, "Nursing Education Leadership" class, April 5.

Goodman KW et al. "Patients in the crossfire: MDs v JDs and the malpractice reform fiasco. St. Luke Society of South Florida Annual Spring Bioethics Symposium at Holy Cross Hospital, Fort Lauderdale, May 5.

Goodman KW. Bioethics in a persistent legislative state. "Hot Issues in Healthcare," Palm Beach Medical Society, VA Medical Center and Legal Aid Society of Palm Beach County, West Palm Beach, May 6.

Goodman KW. Ethical and legal issues. Caregiver Workshop, UMSylvester Comprehensive Cancer Center and National Brain Tumor Foundation, Fort Lauderdale, June 4.

Callahan K, Goodman KW. Ethics and homelessness. Institute of Homeless Studies, Camillus House, Research, roles and resources: The Rx for ending chronic homelessness, Miami, September 26.

Goodman KW. When enough is enough: Making end-of-life decisions. Fawcett Memorial Hospital Medical Staff, Port Charlotte, Florida, October 6.

Goodman KW. Bioethics. Center for Humanism, Unitarian Universalist Congregation, South Miami, Nov. 30.

Goodman KW. Stem cell research and therapy: Political confusion, religious diversity and ethical principles. Brandeis University National Women's Committee, South Dade Chapter, Dec. 8.

2004

Goodman KW. Ethics: A secular perspective. Temple Kol Tikvah, Parkland, Fla., March 23.

Goodman KW, panelist. Getting Beyond Getting Along: Facing the Diversity of Miami-Dade's Ethical Traditions. UM Community Forum, Spring 2004 Series: Democracy in Miami: A Work in Progress, Coral Gables, Fla., April 14.

Goodman KW. Civic responsibility: The balance of ethics and quality of life. Greater Naples Chamber of Commerce leadership seminar. Naples, Fla., April 21.

Goodman KW. Business ethics and corporate governance in a post-Enron environment. Progress Club of Miami, July 14.

Goodman KW. Science and policy in Florida. MiamiIntelligence community forum, July 14, 2004.

Goodman KW. Moderator, Miami-Dade mayoral candidates ethics forum, League of Women Voters and Miami-Dade Commission on Ethics, Coral Gables, Aug. 12.

Goodman KW. Living well, dying well: Conversations and conflicts. Christ the King Lutheran Church, Pinecrest, Fla., Oct. 13.

Goodman KW. Ethics and guardianship. Broward County Guardianship Association, Pompano Beach, Oct. 20.

Goodman KW. Ethics and medical decision making. Broward County guardianship training program, Fort Lauderdale, Oct. 23.

2003

Member, Advisory Committee, Clergy End-of-Life Education Project, Hospice Foundation of America.

Reisner A, Goodman KW. Are we pushing the limits? Defining ethical boundaries of biotechnology research. Second Annual Wilstein Institute Forum at Beth David Congregation, Miami, Feb. 10 (Wilstein Institute of Jewish Policy Studies).

Goodman KW. Ethics, health and guardianship. Florida State Guardianship Association, Gulf Coast Chapter Winter Conference, Sarasota, Feb. 20.

Goodman KW. Ethical implications of HIPAA. Naples Community Healthcare System, Naples, Florida, Feb. 21.

Goodman KW. Data sharing and secrecy in science. Baptist Health South Florida, Third Annual IRB Educational Retreat, Duck Key, Fla., Sept. 20.

Goodman KW. Ethics and guardianship. South Florida Guardianship Association, Miami, Oct. 1.

Goodman KW. How to speak with your physician about end-of-life wishes. Indian River Memorial Hospital/Indian River County Main Library, Vero Beach, Fla., Oct. 17.

Goodman KW. Ethics in cancer care. Cascades Chapter, Papanicolaou Corps for Cancer Research, Boynton Beach, Oct. 22.

2002

Goodman K. Moderator, Symposium on stem cell research. With Prof. Mary Jo Iozzio, Barry University, Rabbi Joshua Kreindler, Jewish Federation of Broward County, Maulana Shafayat Mohamed, Darul Uloom Islamic Institute, Ani Karma Chotso, Kagyu Shedrup Choling Center. Temple Beth El, Hollywood, March 3.

Goodman K. Interviewee, South Florida Radio Broadcasters Association "ascertainment Interviews," June 19, 2002.

Goodman K. Session chair, Legal and Social Issues, Caring for the Elderly; sponsors: Jewish Federation of Broward County, Archdiocese of Miami, Holy Cross Hospital, Fort Lauderdale, Oct. 9.

Goodman K. Between the futile and the miraculous: Ethical, spiritual and social responses to new technology. South Florida Clergy Seminar, JMH Clinical Pastoral Education program, Oct. 23.

Iozzio MJ, Goodman KW. Stem cell research: The possibilities and perils. Tower Forum debate, Fort Lauderdale, Dec. 5.

2001

Goodman K. Religion and bioethics. South Florida Chaplains Association, Holy Cross Hospital, Fort Lauderdale, March 12.

Goodman K. Bioethics committees and end-of-life care. South Florida Guardianship Association, Miami, April 4.

Goodman K. Palliative and end-of-life care: Issues in respiratory therapy. Ninth Annual Harry Kapp Symposium, South Miami Hospital, Oct. 23.

Goodman K. NICU ethics: Challenges and solutions. South Miami Hospital NICU Update, Nov. 2.

2000

Goodman K. Medical ethics. Medical and Health Care Division, Greater Miami Jewish Federation, Miami, Jan. 12.

Goodman K. What is politics? And panel moderator, Business and politics in Miami-Dade. Greater Miami Chamber of Commerce, Leadership Miami program, Hialeah, March 4.

Goodman K. "Patient Rights," Post Polio Association of South Florida, Miami, April 16.

Goodman K. Business, Government and Professional Ethics, Concerned Matrimonial Lawyers of Dade County, Inc., Miami, Sept. 27.

Caralas P, Goodman K. Panelists, topics in health ethics, The Changing Face of America's Health Care, Miami Fellows Initiative, Dade Community Foundation, Oct. 27.

1999

Goodman, K., panelist, Facing the Challenge of Aging Parents: Legal, Moral and Social Issues. Temple Judea, Coral Gables, Fla., Jan. 12.

Goodman, K., keynote speaker, Alliance for Aging awards luncheon, "Real-World Good News: Bioethics in the Next Century," Miami, Jan. 21.

Goodman, K., Business Ethics in Health Care, Greater Miami Chamber of Commerce Health Industry Group, Miami, March 2.

Goodman, K, Medical Ethics, Adult Education Program, Temple Solel, April 16, Hollywood, Fla.,

Goodman, K. Banquet Address, Alpha Epsilon Delta, National Pre-Medical Honor Society, University of Miami chapter, Initiation Banquet, April 23.

Goodman, K. (et al.), Facilitator, "Choices When Values Collide," Palm Beach Area Agency on Aging, May 14, 1999, West Palm Beach, Fla.

Goodman K. Advance directives and living wills" Post Polio Association of South Florida, Sept. 18, Miami.

1998

Goodman, K. Difficult Cases for Ethics Committees, Doctors Hospital, Coral Gables, Fla., Jan. 17.

1997

Goodman K. Jewish Medical Ethics, Central Agency for Jewish Education, Fort Lauderdale, Feb. 26.

Goodman, K. Treatment Refusal by Incompetent Patients, South Florida Evaluation and Treatment Center, Miami, March 14.

Goodman, K. Ethics and Epidemiology, Florida International University Department of Public Health, Bioethics in Public Health course, April 9.

Panel moderator, When Enough is Enough: A Discussion on End of Life Issues, Health Council of South Florida, Miami, April 29.

Panelist, Medical Challenges to Religious Values, Meyer Baskin and Florence Baskin-Gordon Memorial Temple Judea/Technion Annual Lecture, Temple Judea, Coral Gables, Fla., May 7.

Goodman, K. Intensive Ethics Seminar, Florida Council of Operating Room Nurses, Aventura, Fla., July 19.

Panelist, "Religious and Ethical Perspectives on the Embargo, Cuban Health and Nutrition and the U.S. Embargo, Cuban Committee for Democracy and Olof Palme International Center, Miami, Sept. 13.

1996

Goodman, K. Rationing Health Care by Age. Huntington Lakes Condominium Association, Delray Beach, Florida, Feb. 9.

Goodman, K. "Role and Function of Ethics Committees," Epworth Village Retirement Community, April 10.

1995

Goodman K, Eisenstat MB. Gene therapy. Temple Judea, Coral Gables, Fla., Dec. 6, 1995.

Goodman, K. Panelist, Science, Technology and Humanity: Shaping a New Creation, Phi Theta Kappa national honor society, Broward Community College, Pembroke Pines, June 10, 1995.

Goodman, K. Patient Rights, Risk Management Seminar for Physicians, South Shore Hospital, Miami Beach, May 1, 1995

Goodman, K. Ethics at the End of Life, South Florida Association of Phi Beta Kappa, Miami, March 19, 1995.

Goodman, K. Progress in Ethics, Leadership Broward Health Day, Hollywood, Fla., March 10, 1995.

Goodman, K., Needell, M. Bioethics and Risk Management, Parkway General Medical Center Medical Staff, North Miami Beach, March 2, 1995.

Goodman, K. Ethics and Health Care Reform, Martin Memorial Medical Center, Stuart, Fla. "Ethics and Health Care Reform: A Workshop on Biomedical Ethics", May 4, 1994.

Goodman, K. Privacy, presented to Pittsburgh Professional Chapter of Women in Communications, March 19, 1991.

Goodman K, et al. Business & ethics. Greater Miami Chamber of Commerce, Miami, Jan. 20.

1994

Goodman K. Role of the ethics committee. North Broward Hospital District, "Update for Ethics Committees and Healthcare Workers," Fort Lauderdale, Nov. 5.

Goodman K. Coping with ethical dilemmas in health care reform, "Business Strategies for the Advanced Health Care Professional," Fort Lauderdale, Oct. 14.

Goodman K, panelist, Animal rights in education and research, "Human Values and the Environment," Dade Environmental Action Council, Miami, Oct. 22.

1993

Goodman K. Different cultures/different ethics? South Miami Hospital Cardiology Conference CME program, July 9.

31a. Other Community/Professional Service

1995-2016 Health Council of South Florida Ethics Committee

2009-2014 Member, Advisory Board, Victor Center for the Prevention of Jewish Genetic Diseases

2010	Member, Conflict of Interest Task Force, American Medical Informatics Association
2003-2010	Member, Board of Directors, Guardianship Program of Miami-Dade County
2004-2010	Chair, Academic Advisory Board, Youth Ethics Initiative
2005-2007	Member Florida PTA Child Protection Committee
2007-2008	Member, Miami-Dade County Commission on Ethics and Public Trust Ethics, Integrity and Accountability Task Force

**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

REBUTTAL DECLARATION OF ARON JANSSEN, M.D.

I, Aron Janssen, M.D., hereby declare and state as follows:

1. I am over 18 years of age, of sound mind, and in all respects competent to testify.
2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. The opinions expressed in this declaration are my own and do not express the views or opinions of my employer.
3. I have actual knowledge of the matters stated in this declaration. If called to testify in this matter, I would testify truthfully and based on my expert opinion.
4. I incorporate as part of this rebuttal declaration my opinions and qualifications set forth in the expert declaration I previously filed in this matter

(Doc. 17-2).

5. I submit this rebuttal declaration to respond to the expert declarations from James Cantor (Doc. 47-9), Michael Laidlaw (Doc. 47-10), Stephen Levine (Doc. 47-11), and Geeta Nangia (Doc. 47-12), which Intervenor-Defendant Daniel Cameron has submitted in this case. In preparing this rebuttal declaration, I have relied on my training and years of research and clinical experience, as set out in my *curriculum vitae* (attached as **Exhibit A** to my original declaration) and on the materials listed therein; the materials listed in the bibliography attached as **Exhibit B** to my original declaration; and the additional materials listed in the supplemental bibliography attached as **Exhibit C** to this rebuttal declaration. The sources cited in each of these are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject, which include authoritative, scientific peer-reviewed publications. 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 and issues that may arise in my area of expertise. I may also further supplement these opinions in response to information produced by Defendants in discovery and in response to additional information from Defendants' designated experts.

SUMMARY OF OPINIONS

6. The declarations submitted by Intervenor-Defendant Cameron’s designated experts largely argue about hypothetical concerns, for which there is no proof, and the limitations of particular studies. But these witnesses completely ignore that the evidence base for the safety and efficacy of medical treatment for gender dysphoria is not based on any one particular study. Rather, as is the norm in all of science and medicine, we look at the entire body of research surrounding gender-affirming care. When one does so, the conclusion that medical care for the treatment of gender dysphoria in transgender adolescents and adults is safe and effective becomes inescapable. Decades of clinical experience further support this conclusion.

7. Intervenor-Defendant Cameron’s experts further ignore the robust evidence for the harm faced by transgender individuals when barred access to medically necessary gender-affirming care.

8. Medical care for gender dysphoria, including puberty-delaying medications or hormone therapy for transgender adolescents when medically indicated, is safe and effective, and it is not substandard or experimental.

9. Understanding patients’ experience of gender dysphoria is a vital component of being an expert in this field. Without understanding the distress transgender patients face – as well as the joy and resilience they experience when

they get the care they need – one is only spouting unmoored and unfounded opinions. Medicine and science demand more than just personal opinions, it demands study and experience in the field. For the most part, Intervenor-Defendant Cameron’s experts lack both.

EXPERT OPINIONS

I. RESPONSES TO DR. LEVINE AND GENERAL RESPONSES TO INTERVENOR-DEFENDANT’S OTHER EXPERTS

A. Dr. Levine Lacks the Experience and/or Training to Opine on the Diagnosis, Assessment, and Treatment of Gender Dysphoria in Transgender Children and Adolescents

10. Because Dr. Levine does not appear to be board certified in child and adolescent psychiatry, he lacks the related experience and training in specific developmental considerations for children and adolescents that is critical for working with transgender youth and their families.

11. Moreover, Dr. Levine repeatedly acknowledges in his declaration that he has no firsthand knowledge of how gender-affirming mental health care is actually provided to children and adolescents. His descriptions are based on second-hand conversations and often sensationalized media reports. (*See, e.g.*, Levine Decl. ¶ 45 (offering opinions based on anecdotal reports from the internet)). He speaks in his declaration with authority on developmental and family factors that shape identity development in youth despite lacking the requisite training and experience and even ascribes reasons for why boys and girls may pursue social transition despite

no clinical experience in the relevant population.

B. Dr. Levine and Intervenor-Defendant’s Other Experts Display a Misunderstanding of the Nature of Gender Identity and of the Harm Caused by Attempting to Alter Gender Identity

12. Every person has a gender identity, and it is not a personal decision, preference, or belief. A transgender boy cannot simply turn off his gender identity like a switch, any more than a non-transgender boy or anyone else could.

13. Living in a manner consistent with one’s gender identity is critical to the health and wellbeing of any person, including transgender people.

14. The lack of evidence demonstrating that gender identity can be altered, either for transgender or for non-transgender individuals, further underscores the innate nature and immutability 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 extreme psychological damage.

15. A recent study found that experiencing those conversion efforts was associated with greater odds of attempting suicide, especially for those who had those experiences in childhood (Turban, et al., 2020b). That conclusion is further supported by the extensive evidence that rejection of a young person’s gender identity from family and peers are the strongest predictors for adverse mental health outcomes. Every leading medical and mental health organization has issued clear

statements that those practices are discredited, harmful, and ineffective, including the American Medical Association (2022), the American Psychiatric Association (2018), the American Academy of Child & Adolescent Psychiatry (2018), the American Psychological Association (2021), and the American Academy of Pediatrics (Rafferty, et al., 2018), among others.

16. Dr. Levine notes in his declaration “it is widely agreed that the therapist should not directly challenge a claimed transgender identity in a child.” (Levine Decl. ¶ 46). This characterization misunderstands the standard of care for providing competent therapy to a minor with gender dysphoria, which includes challenging assumptions based on gender stereotypes and encouraging a child to build nuance around identity. However, what Dr. Levine seems to be arguing for is not to encourage a psychotherapeutic process that helps a child come to a clear and nuanced sense of self, whatever the gender identity may be, but instead recommending a psychotherapeutic intervention that seeks to prevent a child from being transgender. There is no evidence that such efforts are effective, and significant evidence that they put youth at risk of serious harms.

17. By foreclosing the possibility of a healthy transgender identity and instead encouraging these transgender youth who will persist into transgender adults to strive towards a cisgender outcome, as Intervenor-Defendant Cameron’s experts argue, one is, by definition, practicing conversion therapy.

18. Dr. Levine and Intervenor-Defendant Cameron’s other experts devote a great deal of space to discussing a theory that an increasing number of people who are assigned female at birth are suddenly identifying as males in mid-to- late adolescence as a result of peer pressure and social contagion. (See, e.g., Levine Decl. ¶¶ 90-91; Cantor Decl. ¶ 135; Nangia Decl. ¶¶ 33-36; Laidlaw Decl. ¶¶ 208-211). The theory that some adolescents experience “rapid- onset gender dysphoria” as a result of social influences is based almost exclusively on one highly controversial study (Littman, 2018). Although purporting to provide a basis for Dr. Levine’s speculations, the study was based on an anonymous survey, allegedly of parents, about the etiology of their child’s gender dysphoria. Participants were recruited from websites promoting this social contagion theory, and the children were not surveyed or assessed by a clinician. Those serious methodological flaws render the study meaningless. The only conclusion that can be drawn from that study is that a self-selected sample of anonymous people recruited through websites that predisposed participants to believe transgender identity can be influenced by social factors do, in fact, believe those social factors influence children to identify as transgender.

C. The Guidelines for Treatment of Gender Dysphoria Are Evidence-Based

19. The World Professional Association of Transgender Health (WPATH) has issued Standards of Care for the Health of Transgender and Gender Diverse People (“WPATH Standards of Care”) since 1979. The current version is SOC 8,

published in 2022. The WPATH Standards of Care provide guidelines for multidisciplinary care of transgender individuals, including children and adolescents, and describes criteria for medical interventions to treat gender dysphoria, including hormone treatment and surgery when medically indicated, for adolescents and adults.

20. Contrary to Dr. Levine's claims, SOC 8 is based upon a rigorous and methodological evidence-based approach. (Coleman, et al., 2022). Its recommendations are evidence-based, informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options, as well as expert consensus via a Delphi procedure. The process for development of SOC 8 incorporated recommendations on clinical practice guideline development from the National Academies of Medicine and The World Health Organization. Its recommendations were graded using a modified GRADE methodology (Guyatt, et al., 2011), considering the available evidence supporting interventions, risks and harms, and feasibility and acceptability.

21. A clinical practice guideline from the Endocrine Society (the Endocrine Society Guidelines) provides similar protocols for the medically necessary treatment of gender dysphoria. (Hembree, et al., 2017).

22. Each of these guidelines are evidence-based and supported by scientific research and literature, as well as extensive clinical experience.

23. Each of these guidelines also provides distinct guidance for age-appropriate care for children, adolescents, and adults with gender dysphoria. And none of these guidelines recommend medical treatment for prepubertal children, meaning no medical treatment is recommended until after the onset of puberty.

24. The protocols and policies set forth by the WPATH Standards of Care and the Endocrine Society Guidelines are endorsed and cited as authoritative by the major professional medical and mental health associations in the United States, including the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, the American College of Obstetrics and Gynecology, the American College of Physicians, and the World Medical Association, among others.

D. Intervenor-Defendant’s Experts’ Discussion of Gender Diverse Children Who Desist Before Puberty Is Largely Irrelevant and Erroneous in Many Respects

25. Intervenor-Defendant Cameron’s experts spend substantial portions of their declarations criticizing supportive care for prepubertal transgender children. For example, according to Dr. Levine, studies have indicated that gender dysphoria in prepubertal gender diverse children may desist by the time the children reach puberty, and thus medical professionals should adopt a “watchful waiting” approach and avoid affirming a prepubertal child’s gender identity.

26. However, with regards to prepubertal gender diverse children, the

WPATH Standards of Care state that prepubertal gender diverse children “are not eligible to access medical intervention,” and therefore focuses on developmentally appropriate psychosocial practices. This case concerns a ban on certain types of medical treatment, namely, puberty delaying medications and hormones, and none of those treatments are recommended for transgender youth until after the onset of puberty (i.e., until adolescence). Even then, such treatments are available only when it is medically necessary, age appropriate, and the legal caregivers consent.

27. As such, many of Dr. Levine’s and Intervenor-Defendant Cameron’s other experts’ litany of criticisms is largely irrelevant to the population of people affected by Kentucky’s medical care ban. For example, a significant number of Dr. Levine’s and the other experts’ arguments relate to prepubertal children who “desist” from expressing a transgender identity once they reach puberty. While many of the statements being made about this population are erroneous, they are also largely irrelevant.

28. That said, to avoid any confusion, I address some of Dr. Levine’s and the other experts’ arguments pertaining to prepubertal transgender youth here.

29. As with all health care, treatment of prepubertal gender diverse children is individualized based on the needs of the child and the family and other psychosocial considerations and is decided upon only after a discussion of possible benefits and risks (Hidalgo, et al., 2013). As part of those discussions, the child and

their family are advised that prepubertal gender diverse children do not always go on to identify as transgender when they reach adolescence, and that children are encouraged to continue developing an understanding of their gender identity without expectation of a specific outcome even after social transition takes place (American Psychological Association, 2015; Edwards-Leeper and Spack, 2012).

30. The term “gender diverse” includes transgender children as well as children who will ultimately not identify as transgender later in life (Coleman, et al., 2022).

31. Dr. Levine and Intervenor-Defendant Cameron’s other experts present a caricatured description of prevailing standards of care that reflects a profound misunderstanding of the subject with respect to prepubertal gender diverse children. Mental health providers cannot change a prepubertal child’s gender identity or prevent them from being transgender, just as mental health providers cannot change a cisgender child’s gender identity. Furthermore, it is far from the standard of care for clinicians to blindly support a child’s potential social transition without careful assessment and a thorough discussion of the risks, benefits and alternatives of this intervention.

32. Prepubertal children who “desist” are children with nonconforming gender expression who realize with the onset of puberty that their gender identity is consistent with their sex assigned at birth. Their understanding of their gender

identity changes with the onset of puberty, but their gender identity does not. We cannot definitively determine which prepubertal children will go on to identify as transgender when they reach adolescence, but we know that children with gender dysphoria who persist into puberty are more likely to have expressed a consistent, persistent, and insistent understanding of their gender identity from a young age (Steensma, et al., 2013).

33. The focus of SOC 8 is thus in supporting the overall health and wellbeing of the child. In this manner, the primary goal of supportive care is to help a child understand their own gender identity and build resilience and mental wellness in a child and family, without privileging any one outcome over another.

34. Important considerations in deciding whether social transition is in a child's best interest include: whether there is a consistent, stable articulation of a gender different from the child's sex assigned at birth, which should be distinguished from merely dressing or acting in a gender non-conforming manner; whether the child is expressing a strong desire or need to transition; the degree of distress the child is experiencing as a result of the gender dysphoria; and whether the child will be emotionally and physically safe during and following transition (Coleman, et al., 2022; American Psychological Association, 2015).

35. A treatment plan is informed by a psychosocial assessment, which may vary greatly depending on the patient's presentation and the complexity of the

issues the patient is navigating. Further, in conducting that assessment, the mental health provider is drawing from their professional training and experience in working with transgender young people, exercising professional judgment, and tailoring the assessment to each individual patient.

36. There is also no requirement that prepubertal children who socially transition receive mental health therapy. Many prepubertal children who express a gender identity different from their sex assigned at birth do not experience any co-occurring conditions or other psychological distress requiring treatment (Coleman, et al., 2022; de Vries, et al., 2011a). Mental health therapy may be useful for some prepubertal children but is not necessary or appropriate for everyone. Forcing children to undergo therapy when it is not medically indicated is both harmful and unethical.

37. Dr. Levine and Intervenor-Defendant Cameron's other experts seem to think social transition is a single decision that irrevocably alters a child's trajectory over time. This belief belies their lack of clinical experience in working with gender diverse pre-pubertal youth. Clinically, social transition is often a series of steps taken gradually with feedback from the child, the family, and the clinician elicited over time. It is false that allowing prepubertal transgender children to socially transition puts these children on a path to becoming transgender adolescents and adults. Rather, the evidence shows that the same prepubertal children who are likely to have a stable

transgender identity into adolescence are the children who are most likely to articulate a strong and consistent need to socially transition (Steensma, et al., 2013). For example, a recent study found that a group of transgender children who transitioned before puberty and a group of transgender children who waited to transition until after puberty both showed the same intensity of cross-gender identification. In other words, socially transitioning before puberty did not increase children's cross-gender identification, and deferring transition did not decrease cross-gender identification (Rae, et al., 2019).

38. Intense cross-gender identification and a strong, persistent desire to transition is simply an indicator that a child is more likely to be transgender and not merely gender nonconforming.

E. In Adolescents, Evidence Shows That Treatment of Gender Dysphoria with Puberty-Delaying Medications and Hormones Positively Impacts Psychological Functioning and Quality of Life, and Withholding Treatment is Harmful

39. The criticisms of medical care for adolescents by Dr. Levine and Intervenor-Defendant Cameron's other experts reflect a distorted interpretation of the relevant scientific literature and the nature of this care.

40. Dr. Levine and Intervenor-Defendant Cameron's other experts criticize the methodology of studies supporting the WPATH standards of care while proposing a "therapy only" treatment without any empirical or scientific support whatsoever.

41. Adolescents with gender dysphoria who have entered puberty 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. Puberty-delaying medications allow the adolescent time to better understand their gender identity, while delaying distress from the progression of the development of secondary sex characteristics such as breasts or facial hair.

42. Prior to initiation of puberty-delaying medications, providers counsel patients and their families on potential benefits and risks. The intended benefit of treatment is to reduce the risk of worsening gender dysphoria and mental health deterioration. More specifically, use of puberty-delaying medications in transmasculine adolescents allows for decreased chest development, reducing the need for breast binding and surgical intervention in adulthood. For transfeminine adolescents, puberty-delaying medications limit facial and body hair growth, voice deepening, and masculine bone structure development, which greatly reduce distress both at the time of treatment and later in life and reduce the need for later interventions such as voice therapy, hair removal, and facial feminization surgery. The goal in using puberty-delaying medications is to minimize the patient's dysphoria related to progression of puberty and allow for later initiation of puberty consistent with gender identity. The pubertal stage and individual needs of the

patient direct conversations regarding care options.

43. A growing body of evidence, including peer-reviewed cross-sectional and longitudinal studies, demonstrates the positive impact of pubertal suppression in adolescents with gender dysphoria on psychological functioning and quality of life, including a decrease in behavioral and emotional problems, a decrease in depressive symptoms, and improvement in general functioning (e.g., Achille, et al., 2020; Turban, et al., 2020a; van der Miesen, et al., 2020; Costa, et al., 2015; de Vries, et al., 2011b). Furthermore, studies show improvements in body satisfaction with gender-affirming treatment, and the extant literature recognizes that the body satisfaction is a mediator for improved quality of life and mental health outcomes. (Chen, et al., 2023).

44. In my own practice, I have had patients describe pubertal suppression as lifesaving and the vast majority have experienced a great deal of relief when the treatment is initiated. In some cases, being on puberty blockers has enabled a youth to understand their gender identity to be consistent with their assigned sex; these youth discontinue this treatment and resume puberty. While each patient and each family is unique, a thorough assessment and a clear discussion of the risks, benefits and alternatives of this interventions is consistent among all of my patients.

45. After ongoing work with mental health professionals and when the adolescent has lived in accordance with their gender identity for a significant period

of time, they may start treatment with hormones (testosterone for transgender boys, estrogen and testosterone suppressants for transgender girls), if and when medically indicated.

46. There is no credible basis for Dr. Levine’s assertion that an adolescent’s decision to begin puberty-blocking medication “act[s] as a psychosocial ‘switch,’ decisively shifting many children to a persistent transgender identity.” (Levine Decl. ¶ 129). Studies showing that a high percentage of transgender adolescents who receive puberty blockers ultimately decide to move forward with gender-affirming hormone therapy more likely reflect the fact that participants were rigorously screened and had demonstrated sustained, persistent gender dysphoria before receiving medical treatment.

47. Eligibility and medical necessity are determined case-by-case, based on an assessment of the adolescent’s unique cognitive and emotional maturation and ability to provide a knowing and informed assent in addition to the informed consent of the legal medical decision maker, most often the parent or guardian. The decision would be made only after a careful review with the youth and parents/guardians of the potential risks and benefits of hormone therapy.

48. Under SOC 8 and the Endocrine Society Clinical Guidelines, 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, and 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).

49. As with puberty-delaying medications, the risks and benefits of hormone treatment are discussed with the patient and their families, prior to initiation of hormone therapy.

50. And, as with the use of puberty-delaying medications, 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).

51. In my own practice, I have seen youth with severe gender dysphoria who avoided all social contacts who were able to thrive with the initiation of gender affirming hormones and feel confident with the changes seen as they developed secondary sex characteristics aligned with their gender identity. I have seen my

patients start hormones and find themselves more able to build social and romantic relationships and begin to address underlying co-occurring psychiatric disorders.

52. When viewed as a comprehensive body of research, the weight of the evidence and the experience of clinicians as well as from the experience of patients has demonstrated that puberty-delaying medication and hormones have been associated with a variety of mental health benefits across different contexts (Chen, et al., 2023; de Vries, 2023).

53. Dr. Levine also criticizes the quality of evidence supporting treatment of gender dysphoria. (See, e.g., Levine Decl. ¶¶ 80-81, 121, 134-36; Cantor Decl. ¶¶ 72, 247). But treatments for gender dysphoria have the same or similar level of evidentiary support as many other well-established treatment protocols in psychiatry—and other disciplines of medicine. The evidentiary basis for those treatment protocols is developed, and regularly updated, using a combination of peer-reviewed research and the extensive clinical experience of providers who regularly treat patients with that condition. Those treatment protocols are considered the standard of care and are safe and effective for the conditions they are intended to treat.

54. Dr. Levine also suggests that the lack of FDA approval of medical treatments for these specific uses indicates that the treatments are not supported by evidence of safety. (See, e.g., Levine Decl., ¶ 174). But off-label use of medication

is common in medicine, especially treatments for children and adolescents. For example, in children, Zoloft is FDA approved to treat Obsessive-Compulsive Disorder, but is also regularly used to treat depression and anxiety, such that the use of Zoloft is considered the standard of care for children who medication to treat those conditions despite the lack of FDA approval for those indications.

55. In his declaration, Dr. Levine suggests that the WPATH Standards of Care require the unquestioned and automatic affirmation of an adolescent's desires. This is false. Medical treatments such as GAH are provided to an adolescent only after careful evaluation and working with the adolescent and their parents/guardians, who are the ones who provide the informed consent, including addressing any co-occurring psychiatric disorders.

II. RESPONSES TO DR. CANTOR

A. Dr. Cantor Lacks the Experience and/or Training to Opine on the Diagnosis, Assessment, and Treatment of Gender Dysphoria in Transgender Children and Adolescents

56. Based on his declaration and curriculum vitae, Dr. Cantor does not appear to have sufficient training or clinical experience to offer expert opinions regarding the diagnosis and treatment of gender dysphoria in children and adolescents. He discusses his work on academic journals and as a member of the American Psychological Association ("APA"), but Dr. Cantor's CV does not indicate he has ever been on a review board or an editor of a journal that specializes

in transgender health. Instead, he has worked with journals that focus on sexuality, sexual behavior, and sexual abuse. His conference presentations and journal publications primarily focus on pedophilia, sex offenders, and hypersexuality. Only a handful of his presentations and publications (most of which were not research) appear to have some connection to transgender people.

57. Dr. Cantor does not appear to have ever treated a minor with gender dysphoria. He does not indicate that he has ever diagnosed a child or adolescent with gender dysphoria, nor does he appear to have ever monitored or supervised any minor patient receiving medication to treat gender dysphoria.

B. Dr. Cantor’s Criticisms of the Standards of Care Are Not Well Founded

58. Dr. Cantor claims that the standards of care for gender dysphoria lack a sufficient evidentiary basis. As stated above with respect to Dr. Levine’s similar criticisms, the standards of care are evidence-based. WPATH and the Endocrine Society developed these standards for treating gender dysphoria in minors using the same evidence-based approach used to develop standards of care and practice guidelines for the treatment of many other medical conditions. (Coleman, et al., 2022; Hembree, et al., 2017).

C. Dr. Cantor’s View That Transgender Adolescents Should be Prohibited from Receiving Supportive Medical Care is Not Well Founded

59. Dr. Cantor appears to believe that adolescents who are diagnosed with

gender dysphoria should not be permitted to transition either socially or with medication. Instead, Dr. Cantor seems to believe children and adolescents should be given counseling to discourage them from identifying as transgender. This view appears to be based on his opinion that gender dysphoria in children and adolescents is a manifestation of some other mental health condition, such as borderline personality disorder. (Cantor Decl. ¶ 151 (advancing the “hypothesis that mental health issues, such as Borderline Personality Disorder (BPD), cause both suicidality and unstable identity formation (including gender identity confusion).”).

60. Dr. Cantor’s views on this topic have no scientific basis. Contrary to Dr. Cantor’s views, some children and adolescents are in fact transgender. Gender dysphoria is a real and distinct medical condition. It is not a manifestation of “gender identity confusion” caused by other “mental health issues.” (Cantor Decl. ¶ 151) There is no basis for Dr. Cantor to claim that patients who have borderline personality disorder are regularly being misdiagnosed with gender dysphoria. There are no studies that support Dr. Cantor’s claims.

61. Dr. Cantor rejects the use of the term “conversion therapy” to describe counseling that aims to discourage children and adolescents from identifying as transgender, based on his inaccurate claim that the research on conversion therapy has exclusively addressed sexual orientation and that its results cannot be extrapolated to gender identity. (Cantor Decl. ¶ 267.) As noted above, research has

found an increased likelihood of suicide attempts for those who have experienced conversion efforts, especially as minors (Turban, et al., 2020b). Every leading medical and mental health organization has issued clear statements that opposing those practices as harmful and ineffective in changing a person's gender identity.

62. Dr. Cantor uses an outdated and inaccurate definition of sex. Dr. Cantor states that sex can only be determined either by "visual inspection" or "chromosomes." (Cantor Decl. ¶ 104.) In fact, sex involves multiple sex-related characteristics including gender identity, and which also include, among others, internal reproductive organs, external genitalia, chromosomes, hormones, and secondary sex characteristics.

63. Dr. Cantor also incorrectly claims that gender identity is not innate and has no biological foundation. (Cantor Decl. ¶¶ 106-107, 134.) This is false. There is consensus among professional organizations that one's gender identity cannot be changed and it is a "deeply felt, inherent sense" (e.g., American Psychological Association 2021). As the Endocrine Society Clinical Practice Guidelines for Endocrine Treatment of Gender-Dysphoric Persons explain: "although there is much that is still unknown with respect to gender identity and its expression, compelling studies support the concept that biologic factors, in addition to environmental factors, contribute to this fundamental aspect of human development." (Hembree, et al. 2017).

64. To support his view that minors should not be permitted to transition, Dr. Cantor claims that “among prepubescent children who feel gender dysphoric, the majority cease to want to be the other gender over the course of puberty.” (Cantor Decl. ¶ 115.) The studies that are cited in support of this view were not limited to transgender children, but also included children who did not have gender dysphoria and children who did not identify as transgender. As stated above, gender diverse children include transgender children as well as children who will ultimately not identify as transgender later in life. Therefore, the concept of gender dysphoria being “outgrown” does not apply to a large portion of gender diverse children since they did not have gender dysphoria to begin with. All of these studies used criteria for diagnosing gender identity disorder that focused mainly on behaviors (and not identity) and had less specific criteria for distinguishing those with the disorder from other children. The current DSM-5-TR (American Psychiatric Association 2022) gender dysphoria criteria require that children/adolescents identify with a gender that is different from their assigned gender for at least six months, which was not the case for any of the studies that are cited to indicate whether or not a youth will identify experience gender dysphoria in the future (Temple Newhook et al., 2018).

65. Steensma & Cohen-Kettinis (2018) agree that their data have been cited incorrectly to support the purportedly low persistence rates and have stated that their “studies cannot be used to support” the persistence estimation, in that they

never calculated or reported rates of persistence/desistence. They also note that the negative social climate for transgender children and adolescents should be taken into account when reading the data. They further state that their data did not actually reflect gender dysphoria in children and “expect that future follow up studies using the new diagnostic criteria may find higher persistence rates.” (Steensma & Cohen-Kettinis, 2018). Finally, they indicate that the terms “desistence” and “persistence” have been misused; they state that when they were researching youth, there were many youth who may have been “hesitating, searching, fluctuating, or exploring” and that those youth have been misclassified as desisting.” (Steensma & Cohen-Kettinis, 2018).

66. Today, based on current scientific knowledge and clinical practice, researchers and clinicians are much better equipped to differentiate transgender from non-transgender children and adolescents. As the Endocrine Society Practice Guidelines explain: “It may be that children who only showed some gender nonconforming characteristics have been included in the follow-up studies, because the DSM-IV text revision criteria for a diagnosis were rather broad . . . With the newer, stricter criteria of the DSM-5, persistence rates may well be different in future studies” (Hembree, et al. 2017).

67. Dr. Cantor does not dispute that minors whose transgender identification persists into adolescence are likely to continue to identify as

transgender as adults. As recent studies have shown, for “transgender adolescents who, following careful assessment, receive medical necessary gender-affirming medical treatment,” “rates of reported regret...are low” (Coleman et al. 2022).

D. Medical Treatments for Transgender Adolescents Reduce Suicidality and Suicide

68. Dr. Cantor asserts that there is no evidence that medicalized transition significantly reduces rates of suicide or suicidality among transgender youth. (Cantor Decl. ¶ 146.) That is untrue. In fact, studies have repeatedly documented that puberty blocking medication and hormone therapy are associated with mental health benefits for transgender people in both the short and long term, including a dramatically reduced rate of suicidality. (Tordoff, 2022; Green, 2021; Turban, 2020; Achille, 2020; Kuper, 2020; van der Miesen, 2020; Costa, 2015).

69. Dr. Cantor and Dr. Laidlaw cite Dhejne (2011) for the proposition that undergoing sex-reassignment surgery does not decrease suicidality among transgender adults. (Cantor Decl. ¶ 147; Laidlaw Decl. ¶ 203) The study itself warns against drawing any conclusions regarding the effectiveness of surgery as a treatment for gender dysphoria: “For the purpose of evaluating whether sex reassignment is an effective treatment for gender dysphoria, it is reasonable to compare reported gender dysphoria pre and post treatment. Such studies have been conducted either prospectively or retrospectively and suggest that sex reassignment of transsexual persons improves quality of life and gender dysphoria.” (Dhejne,

2011). Since the study was published, Dr. Dhejne has cautioned that interpretations like Dr. Cantor’s and Dr. Laidlaw’s are incorrect. (Dhejne, 2017).

70. Dr. Cantor further opines that McNeil, et al. (2017) does not show that transition reduces suicidality among transgender youth. (Cantor Decl. ¶ 149.) In fact, the study concluded that “[d]iscrimination emerged as strongly related to suicidal ideation and attempts, whereas positive social interactions and timely access to interventions appeared protective.” Bauer, et al. (2015), which Dr. Cantor erroneously cites for the proposition that social support is associated with increased suicide attempts, further supports that conclusion: “Our findings support a strong effect for social exclusion, discrimination and lack of medical transition (for those needing it) on suicide ideation and attempts, and potentially on the survival of trans persons.” The WPATH Standards of Care cite Bauer’s study as evidence that “[a]ccess to gender-affirming medical treatment is associated with a substantial reduction in the risk of suicide attempt (Coleman et al., 2022).

71. Dr. Cantor also cites Canetto, et al. (2021) in support of his claim that providing social support to transgender youth is associated with increased suicidal attempts. (Cantor Decl. ¶ 150.) The Canetto study did not include or address transgender youth and does not support Dr. Cantor’s claim.

72. Dr. Cantor also relies on the lack of research showing that medical treatments for transgender youth reduce suicide as opposed to reducing suicidality

to support his opposition to providing transgender youth with supportive treatment and care. But this gap in the available research does not support his position, for several reasons. First, the absence of data about how treatment impacts suicide as opposed to suicidality largely reflects the difficulty of designing or undertaking such research. The Baker study cited by Dr. Cantor did not find that treatment failed to reduce suicide, but only that it was impossible to draw conclusions because of “the difficulty of identifying appropriate comparison groups and uncontrolled confounding factors.” (Baker, 2021).

73. Second, the harms caused by suicidality are themselves very serious. In a recent systematic review of the impact of suicidal ideation, the harms directly associated with suicidal thoughts are clear: a sense of loss of the self, lack of self-worth, low self-esteem, loss of meaning in life, self-hatred, feelings of worthlessness, increased guilt, and increased shame. (Søndergaard, 2023). These experiences are incredibly painful. Even if suicidality and suicide were not related, which they are, preventing suicidality alone would be a compelling reason to provide medically needed care to transgender adolescents.

74. And third, because suicide attempts and suicide are interrelated, a treatment that reduces the former reduces the latter, even if current research designs cannot quantify that impact precisely. (Jones, 2023). For example, a recent study found that transgender teens were 7.6 times as likely to attempt suicide as their non-

transgender peers. (Kingsbury, 2022). Providing medically necessary care dramatically reduces the suicidality of transgender youth, including reductions in suicide attempts. In one recent study of transgender youth under 18, receiving hormone therapy was associated with nearly 40% lower odds of having had a suicide attempt in the past year. (Green, 2021). Given the relationship between suicide attempts and suicide, there can be little doubt that receiving medically necessary care significantly reduces suicide among transgender youth.

III. RESPONSES TO DR. NANGIA

A. Summary

75. Based on her declaration and curriculum vitae, Dr. Nangia does not appear to have a sufficient clinical basis for offering expert opinions regarding the diagnosis and treatment of gender dysphoria in children and adolescents, or the assessment and informed consent process involved when treating adolescents with gender dysphoria with gender affirming care. Her declaration appears to be based on a series of hypothetical assumptions about how other mental health practitioners are diagnosing minors with gender dysphoria and recommending treatment—without any direct experience doing so herself, and without any apparent knowledge of how care is actually provided by others.

76. Dr. Nangia’s implausible claim to have treated “550 children and adolescents (and hundreds of adults) who have met criteria at some point in their

lives for a ‘gender dysphoria’ diagnosis,” Nangia Decl. ¶ 48, appears to reflect a misunderstanding of how gender dysphoria is diagnosed and an inability to distinguish between people with gender dysphoria—a medical condition requiring clinically significant distress or impairment in social, occupational, or other important areas of functioning—and people who are simply gender nonconforming.

77. While Dr. Nangia speculates that people are being misdiagnosed with gender dysphoria because they are tomboys, or have co-occurring medical conditions, or have experienced trauma, those speculations appear to be based on her own misunderstanding of how gender dysphoria is properly diagnosed.

78. Dr. Nangia also appears to assume that mental health providers working with transgender youth are not explaining risks and benefits and are unfamiliar with principles of informed consent and assent. Once again, that speculation appears to be based on her own misunderstanding of how care is actually provided by specialists in the field.

79. Dr. Nangia also does not appear to have an expert basis for her speculation that an increasing number of youth are being diagnosed with gender dysphoria as a result of factors such as “social media” or “social contagion.” None of Dr. Nangia’s speculation is supported by actual evidence, and her personal opinions do not reflect the common views of experts in the field.

B. Dr. Nangia Lacks Experience or Familiarity with Properly Diagnosing Gender Dysphoria

80. I have significant questions about Dr. Nangia’s actual experience working with transgender youth. Dr. Nangia implausibly claims to have evaluated and treated “550 children and adolescents (and hundreds of adults) who have met criteria at some point in their lives for a ‘gender dysphoria’ diagnosis,” including 350 patients who “had a history of gender dysphoria, as discovered on evaluation or over the course of patient care,” and “close to 100 additional child patients who meet criteria for gender dysphoria on clinical interview during or over the course of treatment with [her]” and “just over 100 adolescents who have presented with gender dysphoria that has been more abrupt in onset.” Nangia Decl. ¶¶ 48-49, 52. While claiming that these 550 children and adolescents met criteria for gender dysphoria, Dr. Nangia does not claim to have provided any actual treatment for that condition.

81. Dr. Nangia appears to derive her claim to have worked with “550 children and adolescents who have met criteria at some point in their lives for a ‘gender dysphoria’ diagnosis,” based on patient case histories that she thinks could have hypothetically supported a gender dysphoria diagnosis. But a proper diagnostic evaluation requires more than reviewing a simple case history. As Dr. Nangia herself notes “in mental health, if a five-year-old patient presented with difficulty with affect regulation, as well as trouble focusing and being still in the

classroom, most physicians would not diagnose ADHD on initial assessment,” and would instead evaluate those symptoms within the context of other psychosocial developments in the child’s life, while keeping in perspective what we know about the typical emotional and neurological development of children that age. Nangia Decl. ¶ 125. Just as most physicians would not immediately diagnosis a 5-year-old child with difficulty in affect regulation as having ADHD, most physicians would not claim to have worked with 550 patients who had ADHD based on the fact that those patients reported having trouble sitting still when they were 5 years old. Nor would most physicians claim to be experts in treating ADHD based on those case histories.

82. Dr. Nangia’s assumption that 550 of her patients *could* have been diagnosed with gender dysphoria also reflects a failure to distinguish between people who have gender dysphoria and people who are simply gender nonconforming. Most critically, Dr. Nangia fails to appreciate that a diagnosis of gender dysphoria in children or adolescents requires “clinically significant distress or impairment in social, occupational, and other important areas of functioning.” (DSM-5- TR).

83. Dr. Nangia concedes she has “difficulty appreciating th[e] distinction” between gender nonconformity and gender discordance. Nangia Decl. ¶ 24. But to be qualified to make a diagnosis, one must understand what that

diagnosis is. That is why mental health providers making a gender dysphoria diagnosis should have the training and experience to provide a thorough and comprehensive evaluation that can distinguish gender non-conforming behaviors from a core incongruence of identity with associated distress. Treating patients with gender dysphoria also involves educating patients and their parents and caregivers about the difference between preferred play, dress, and playmates and core identity concerns.

84. Here and elsewhere, Dr. Nangia inexplicably assumes that mental health providers somehow disregard everything else they know about adolescent development and identity formation when they make a gender dysphoria diagnosis. In reality, when assessing adolescents for gender-affirming medical care, providers engage in a comprehensive assessment that takes precisely these considerations into account. Understanding potential reinforcers of identity and challenging patients' assumptions with an aim of developing a nuanced sense of self is a core component of the diagnostic assessment.

85. Dr. Nangia speculates that people with symptoms of gender dysphoria are not being assessed to see if they have suffered other trauma. Like other mental health providers, mental health providers who specialize in gender dysphoria are familiar with treating traumatized youth. We assess patients for trauma, and we assess for how trauma informs identity or complicates a gender dysphoria

diagnosis. If an adolescent's identity questions are secondary to trauma, that patient would not meet criteria for the diagnosis of gender dysphoria. But transgender adolescents may experience trauma and still have gender dysphoria that independently requires gender-affirming care to be treated properly.

86. Dr. Nangia also speculates that transgender youth are being misdiagnosed when they have other co-occurring mental health conditions. I have extensive clinical and research experience working with transgender youth who have co-occurring mental health diagnoses. The WPATH Standards of Care specifically recommend that providers who assess adolescents for gender-affirming care should have experience and training to distinguish between gender dysphoria and other mental health conditions or developmental anxieties. But the existence of a co-occurring mental health diagnosis is not—by itself—a reason to withhold care for gender dysphoria. It is important that co-occurring conditions are treated. And if co-occurring conditions impair the individual's capacity to understand the interventions in question, we have to treat those conditions before any medical care for gender dysphoria would be initiated. But there is no evidence that treating co-occurring mental health conditions resolves gender dysphoria. In the same way that we would not expect that treating anxiety is going to get rid of ADHD, treating anxiety, for example, is not going to get rid of gender dysphoria.

C. Dr. Nangia Lacks Familiarity With Procedures for Informed Consent to Gender-Affirming Care

87. As with her other speculations, Dr. Nangia wrongly assumes that other mental health providers are not explaining risks and benefits of medical interventions for gender dysphoria or are unfamiliar with principles of informed consent and assent. But a fundamental part of assessment for gender-affirming care is determining whether the minor can understand and articulate to the best of their ability the risks, benefits, and alternatives of that intervention, and determining whether parents can provide consent for that intervention. The risks and benefits associated with gender-affirming care are not more difficult to understand than those associated with other mental health conditions.

88. Dr. Nangia asserts that adolescents have developing brains that cannot think about long-term consequences. But a decision to receive pubertal suppression or hormone therapy for gender dysphoria is not a spur-of-the-moment decision. For gender dysphoria care, it is inherent to our assessment that we are evaluating an individual's cognitive capacity, capacity to understand, and ability to think through potential consequences. These are discussions and assessments that occur longitudinally over time, and these are decisions that adolescents and family are making over a long period and not in a moment.

89. In my psychiatric practice, I have seen a tremendous benefit from these interventions. I have seen individuals who blossom when they are able to

express and live their lives according to their experienced gender after receiving medical intervention to treat gender dysphoria. And I have seen so much joy and improvement in functioning when adolescents receive the care that is clinically indicated.

D. Dr. Nangia’s Speculations About Social Causes of Gender Dysphoria Are Not Based on Any Apparent Expert Knowledge and Lack Scientific Support

90. Access to medical care for transgender youth with gender dysphoria has dramatically improved over the past 20 years. Instead of attributing an increase in the number of gender dysphoria diagnoses to increased access to care, Dr. Nangia speculates about other phenomena that she views as causes. But none of Dr. Nangia’s speculation is supported by actual evidence, and her personal opinions do not reflect the common views of others in the field.

91. Dr. Nangia speculates that children and adolescents are being diagnosed with gender dysphoria because of an “[i]ncrease in pathologization of a normal part of childhood development.” Nangia Decl. ¶ 21. Dr. Nangia acknowledges that “[g]ender-medicine experts today distinguish between tomboys or tomgirls and children with gender dysphoria,” but she speculates without any evidence that “[m]any parents, who in the past simply would not have worried about their children” who are tomboys or tomgirls “are now compelled to consider a diagnosis of gender dysphoria” and that “[p]hysicians likewise, are acting quickly to

usher these children into gender-affirming care.” Nangia Decl. ¶¶ 22, 25. There is no evidence that these sorts of misdiagnoses are occurring in significant numbers by practitioners experienced in providing gender-affirming care. In fact, what we see is the opposite. In clinical care, parents are less likely to be concerned by stereotypical non-conforming behaviors than in the past.

92. Dr. Nangia also attributes gender dysphoria diagnoses to social media. But there is no evidence to suggest that social media has led to an increase in youth identifying as transgender. Nor is this a widely-held belief of most child psychiatrists in my experience.

93. Expertise in a field means drawing from the relevant literature. While not commenting on the quality of the New York Times as a news source, it is not a reference from which psychiatrists should make assertions about their clinical practice. And yet, in quoting from the Wortham 2018 article in the New York Times (Nangia Decl. ¶ 30), Dr. Nangia seems to misunderstand the underlying scientific literature being discussed. The study by Helana Darwin discussed in the New York Times article actually contradicts Dr. Nangia’s assertions that social media leads to an increase in gender dysphoria. (Darwin, 2017). In that article, individuals who already had a non-binary identity sought out online spaces of support. It was not the online space that created the identity.

94. Although Dr. Nangia divides her speculation into different headings

of “social media,” “heightened vulnerability” and “social contagion,” all of these sections reflect the same speculation that more people are identifying as transgender because of social influences. The only evidence Dr. Nangia cites in support of this speculation is a highly controversial article that purported to survey parents who believe their children experienced what the parents view as “rapid onset gender dysphoria,” which is not an actual diagnostic term or concept. (Littman, 2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. (Littman, 2018). Although purporting to provide a basis for Dr. Nangia’s speculations, the study was based on an anonymous survey, allegedly of parents, about the etiology of their child’s gender dysphoria. Participants were recruited from websites promoting this social- contagion theory, and the children were not surveyed or assessed by a clinician. Those serious methodological flaws render the study unreliable. The only conclusion that can be drawn from that study is that a self-selected sample of anonymous people recruited through websites that predisposed participants to believe that transgender identity can be influenced by social factors believe those social factors influence children to identify as transgender.

95. It is a normal developmental process for adolescents to seek out peers with shared experiences. This is not unique to transgender and gender-diverse young people. All types of minoritized youth tend to seek out affinity groups with those

that share their experiences. In my experience, transgender youth also seek out those social connections. It is not the social connections that leads to the identity, but it is the identity that leads to seeking out these social connections.

IV. RESPONSES TO DR. LAIDLAW

96. Expertise in mental health care requires specialized training and ongoing work in the field with appropriate certification and licensure. To my knowledge, and based on a review of his CV, Dr. Laidlaw has neither had the training nor the certification and licensure to weigh in as an expert on the appropriateness of a mental health assessment or treatment plan. This lack of expertise, however, has not stopped him from making broad generalizations about mental health care that bear little resemblance to the care as typically delivered. As such, his characterization of the practice of mental health care should be seen as a lay opinion based on secondhand knowledge at best. Furthermore, expertise in the treatment of transgender individuals requires experience in the care of transgender individuals, a characteristic that Dr. Laidlaw does not possess.

97. Dr. Laidlaw makes many of the same mistakes about consent as the other experts, namely mistaking that children consent to gender affirming medical and surgical care. But he goes further and notes that in his opinion, even parents are unable to provide consent because the full accounting of the potential risks is, according to him, unknown. If Dr. Laidlaw's rubric were to be applied to the rest of

medicine, medicine would never evolve. There are inherent unknown risks to every intervention, and it is the role of the provider to incorporate what is known and what is not known about these risks into a discussion about informed assent and informed consent. Moreover, the fact that we do not know everything about an intervention does not make that intervention experimental. In medicine and in science, every day we discover something and with the advent of new techniques or investigative tools we are able to learn new information about the effects of well-established and longstanding medical interventions. None of this renders a medical intervention to be experimental.

98. Additionally, Dr. Laidlaw spends much of his declaration opining on the appropriateness of the psychiatric care of the patients involved in this case. However, Dr. Laidlaw is not a psychiatrist and has no basis to comment on the psychiatric care of any of these patients. It is unethical for him to do so.

V. PROHIBITING ACCESS TO MEDICAL CARE HARMS TRANSGENDER ADOLESCENTS

99. Intervenor-Defendant Cameron's experts completely ignore the harms associated with prohibiting access to gender-affirming care to adolescents with gender dysphoria for whom it is necessary and appropriate. They also ignore the harmful effects of governmental action like Kentucky's medical care ban.

100. The overarching goal of treatment for gender dysphoria is to eliminate clinically significant distress. For some, this is achieved by aligning an individual

patient's body and presentation with their internal sense of self. The denial of medically indicated care to transgender adolescents not only frustrates this goal and results in the prolonging of their gender dysphoria, but also causes additional distress and poses other health risks, such as depression, trauma, self-harm, and suicidality.

101. Intervenor-Defendant Cameron's experts not only ignore the volumes of data showing the efficacy of gender-affirming medical care, but they also cannot deny that there are transgender adolescents that persist into transgender adults and who benefit from this care. But notwithstanding this latter undeniable fact, Cameron's experts are not interested in a nuanced discussion about prevalence, process, or technique. Instead they advocate for a complete prohibition of this safe, efficacious, and medically necessary care for all transgender adolescents.

102. Lack of access to gender-affirming care therefore directly contributes to poorer mental health outcomes for transgender people (Owen-Smith, et al., 2018).

103. It is also well documented that experiencing discrimination has negative impacts on people's mental health and wellbeing. For example, a 2019 study found that experiencing discrimination in health care settings posed a unique risk factor for heightened suicidality among transgender individuals, a population already at heightened risk compared with the general population (Herman, et al., 2019). And of note, the 2022 National Survey on LGBTQ Youth Mental Health found that LGBTQ youth who had experienced discrimination based on sexual

orientation or gender identity had attempted suicide in the past year at nearly three times the rate as those who had not (19% vs. 7%) (The Trevor Project, 2022).

104. In addition, the 2022 National Survey on LGBTQ Youth Mental Health found that 93% of transgender and nonbinary youth said that they have worried about transgender people being denied access to gender-affirming medical care due to state or local laws (The Trevor Project, 2022).

105. Research has shown that the mere introduction, debate, and adoption of discriminatory laws and policies like the medical care ban negatively affects the mental health of transgender youth. A prospective study with sexual minority populations found that living in states with discriminatory policies was associated with a statistically significant increase in the number of psychiatric disorder diagnoses (Hatzenbuehler, et al., 2010). Other studies “shown that restrictive laws and policies are related to destructive health behaviors on the part of transgender individuals” (Cunningham, et al., 2022; Du Bois, et al., 2018).

106. Recent studies show the negative toll that anti-LGBTQ measures, like Kentucky’s medical care ban, and debates surrounding them have had on the mental health of transgender youth. For example, in a survey of youth in November 2022, 86% of transgender and nonbinary youth said that the debates about anti-transgender bills had negatively impacted their mental health (Movement Advancement Project, 2023; The Trevor Project and Morning Consult, 2023). And a study from 2022

though with limitations, showed that the passage of anti-transgender bills is linked with Internet searches related to depression and suicide (Cunningham, et al., 2022).

107. Perhaps more poignantly, those of us with clinical experience hear from our patients about how it feels to be targeted with this kind of legislation. As two of my transgender patients have expressed to me in recent months, “why does everyone hate me just for existing?” and “it’s a hard time to be transgender right now.”

CONCLUSION

108. By denying access to necessary, safe, and effective medical care as treatment for gender dysphoria, Kentucky’s medical care ban endangers the mental health and well-being of transgender children and adolescents in Kentucky.

109. Intervenor-Defendant Cameron and his experts, who for the most part have no experience in transgender health, not only ignore the robust evidence for the potential harm faced by transgender adolescents when barred access to medically necessary gender-affirming care, but they also mischaracterize, misapprehend, and even ignore the robust body of evidence showing that gender-affirming medical care

is safe, effective, and not experimental or investigational.

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

Executed this 16th day of June 2023.

A handwritten signature in black ink, appearing to read 'A. Janssen', written in a cursive style.

Aron Janssen, M.D.

Exhibit C
Supplemental Bibliography

SUPPLEMENTAL BIBLIOGRAPHY

Achille, C., Taggart, T., Eaton, N. R., Osipoff, J., Tafuri, K., Lane, A., & Wilson, T. A. (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, 8.

Allen, L.R., Watson, L.B., Egan, A.M., & Moser, C.N. (2019). *Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones*. *Clinical Practice in Pediatric Psychology*, 7(3), 302-311.

American Academy of Child and Adolescent Psychiatry. (2018). *Policy Statement: Conversion Therapy*. Available at: <https://www.aacap.org/AACAP/PolicyStatements/2018/ConversionTherapy.aspx>.

American Medical Association and GLMA. (2022). *Issue Brief: Sexual orientation and gender identity change efforts (so-called “conversion therapy”)*. Available at: <https://www.ama-assn.org/system/files/conversion-therapy-issue-brief.pdf>.

American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.). Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association. (2018). *Position Statement on Conversion Therapy and LGBTQ Patients*. Available at: <https://www.psychiatry.org/getattachment/3d23f2f4-1497-4537-b4de-fe32fe8761bf/Position-Conversion-Therapy.pdf>.

American Psychological Association (2021). *APA Resolution on Gender Identity Change Efforts*. Available at: <https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf>.

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

Baker, K. E., et al., *Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review*, *Journal of the Endocrine Society*, Vol. 5, Issue 4, 11-12 <https://doi.org/10.1210/jendso/bvab011> (2021).

- Bauer, G. R., Scheim, A. I., Pyne, J., Travers, R., & Hammond, R. (2015). *Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada*. BMC Public Health, 15, 525. <https://doi.org/10.1186/s12889-015-1867-2>.
- Canetto, S. S., Antonelli, P., Ciccotti, A., Dettore, D., & Lamis, D. A. (2021). *Suicidal as normal: A lesbian, gay, and bisexual youth script?* Crisis, 42, 292–300.
- Chen D, Berona J, Chan YM, Ehrensaft D, Garofalo R, Hidalgo MA, Rosenthal SM, Tishelman AC, Olson-Kennedy J. (2023). *Psychosocial Functioning in Transgender Youth after 2 Years of Hormones*. New England Journal of Medicine, 2023 Jan 19;388(3):240-250.
- Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., Nieder, T. O., ... Arcelus, J. (2022). *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*. International Journal of Transgender Health, 23(Suppl 1), S1–S259.
- Costa, R., Dunsford, M., Skagerberg, E., Holt, V., Carmichael, P., & Colizzi, M. (2015). *Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria*. The Journal of Sexual Medicine, 12(11), 2206–2214.
- Cunningham, G. B., Watanabe, N. M., & Buzuvis, E. (2022). *Anti-transgender rights legislation and internet searches pertaining to depression and suicide*. PloS one, 17(12), e0279420.
- Darwin, H. (2017), *Doing Gender Beyond the Binary: A Virtual Ethnography*. Symbolic Interaction, 40 Symbolic Interaction 317-334.
- de Lara, D.L., Rodríguez, O.P., Flores, I.C., et al. (2020). *Psychosocial Assessment in Transgender Adolescents*. Anales de Pediatría (English Edition), 93(1), 41-48.
- de Vries A. L. C. (2023). *Ensuring Care for Transgender Adolescents Who Need It: Response to ‘Reconsidering Informed Consent for Trans-Identified Children, Adolescents and Young Adults’*. Journal of Sex & Marital Therapy, 49(1), 108–114.

- de Vries, A. L., Doreleijers, T. A., Steensma, T. D., & Cohen-Kettenis, P. T. (2011a). *Psychiatric comorbidity in gender dysphoric adolescents*. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, 52(11), 1195–1202.
- de Vries, A. L., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2011b). *Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study*. *The Journal of Sexual Medicine*, 8(8), 2276–2283.
- de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*. *Pediatrics*, 134(4), 696-704.
- Dhejne, C. et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, *PLOS One*, 6(2):e16885, doi:10.1371/journal.pone.0016885 (2011).
- Dhejne, C. H, *Science AMA Series: I'm Cecilia Dhejne a fellow of the European Committee of Sexual Medicine, from the Karolinska University Hospital in Sweden. I'm here to talk about transgender health, suicide rates, and my often misinterpreted study. Ask me anything!*, *Winnower* 10:e150124.46274 (2017).
- Du Bois, S. N., Yoder, W., Guy, A. A., Manser, K., & Ramos, S. (2018). *Examining Associations Between State-Level Transgender Policies and Transgender Health*. *Transgender Health*, 3(1), 220–224.
- 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(3), 321–336.
- Grannis, C., Leibowitz, S. F., Gahn, S., Nahata, L., Morningstar, M., Mattson, W. I., Chen, D., Strang, J. F., & Nelson, E. E. (2021). *Testosterone treatment, internalizing symptoms, and body image dissatisfaction in transgender boys*. *Psychoneuroendocrinology*, 132, 105358, 1-8.
- Green, A. E., De Chants, J. P., Price, M. N., & Davis, C. K. (2022). *Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*. *The Journal of Adolescent Health: official publication of the Society for Adolescent Medicine*, 70(4), 643–649.

Guyatt, G., Oxman, A. D., Akl, E. A., Kunz, R., Vist, G., Brozek, J., Norris, S., Falck-Ytter, Y., Glasziou, P., & deBeer, H. (2011). *GRADE guidelines: 1. Introduction—GRADE evidence profiles and summary of findings tables*. *Journal of Clinical Epidemiology*, 64(4), 383–394.

Hatzenbuehler, M. L., McLaughlin, K. A., Keyes, K. M., & Hasin, D. S. (2010). *The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: a prospective study*. *American Journal of Public Health*, 100(3), 452–459.

Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, J. D., Tangpricha, V., & T'Sjoen, G. G. (2017). *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*. *The Journal of Clinical Endocrinology and Metabolism*, 102(11), 3869–3903.

Herman, J.L., Brown, T. N. T., & Haas, A. P. (2019). *Suicide Thoughts and Attempts Among Transgender Adults: Findings from the 2015 U.S. Transgender Survey*. The Williams Institute, UCLA School of Law.

Hidalgo, M. A., Ehrensaft, D., Tishelman, A. C., Clark, L. F., Garofalo, R., Rosenthal, S. M., Spack, N. P., Olson, J. (2013). *The Gender Affirmative Model: What We Know and What We Aim to Learn*. *Human Development*, 56(5):285-290.

Jones, S.E., et al., *Mental Health, Suicidality, and Connectedness Among High School Students During the COVID-19 Pandemic—Adolescent Behaviors and Experiences Survey, United States, January-June 2021*, 71(Suppl-3):16-21 (2022), available at, <https://www.cdc.gov/mmwr/volumes/71/su/su7103a3.htm> (last visited May 31, 2023).

Kaltiala, R, Heino, E., Työlajärvi, & Suomalainen, L. (2020). *Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria*. *Nordic Journal of Psychiatry*, 74, 213–219.

Kingsbury, M., et al., *Suicidality among sexual minority and transgender adolescents: a nationally representative population-based study of youth in Canada*, 194 CMAJ E767-74 (June 2022).

Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). *Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy*. *Pediatrics*, 145(4), e20193006.

- Littman L. (2018). *Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria*. PloS one, 13(8), e0202330.
- McNeil, J., Ellis, S. J., & Eccles, F. J. R. (2017). *Suicide in trans populations: A systematic review of prevalence and correlates*. Psychology of Sexual Orientation and Gender Diversity, 4(3), 341–353. <https://doi.org/10.1037/sgd0000235>
- Movement Advancement Project (2023). *Under Fire: The War on LGBTQ People in America*. Available at: https://www.mapresearch.org/file/Under%20Fire%20report_MAP%202023.pdf.
- Owen-Smith, A. A., Gerth, J., Sineath, R. C., Barzilay, J., Becerra-Culqui, T. A., Getahun, D., Giammattei, S., Hunkeler, E., Lash, T. L., Millman, A., Nash, R., Quinn, V. P., Robinson, B., Roblin, D., Sanchez, T., Silverberg, M. J., Tangpricha, V., Valentine, C., Winter, S., . . . Goodman, M. (2018). *Association between gender confirmation treatments and perceived gender congruence, body image satisfaction, and mental health in a cohort of transgender individuals*. Journal of Sexual Medicine, 15(4), 591-600.
- Rae, J. R., Gülgöz, S., Durwood, L., DeMeules, M., Lowe, R., Lindquist, G., & Olson, K. R. (2019). *Predicting early-childhood gender transitions*. Psychological Science, 30(5), 669-681.
- Rafferty, J., Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence, & Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness (2018). *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*. Pediatrics, 142(4), e20182162.
- Søndergaard, R., et al., *Living with Suicidal Thoughts: A Scoping Review*, Scandinavian Journal of Caring Sciences, 37(1), 60-78 (2023).
- Steensma & Cohen-Kettenis (2018). *A critical commentary on “A critical commentary on follow-up studies and “desistence” theories about transgender and gender non-conforming children.”* International Journal of Transgenderism, 19(2), 225-230.
- Steensma, T. D., McGuire, J. K., Kreukels, B. P., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). *Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study*. Journal of the American Academy of Child and Adolescent Psychiatry, 52(6), 582–590.

Temple Newhook, J. T., Pyne, J., Winters, K., Feder, S., Holmes, C., Tosh, J., Sinnott, M.-L., Jamieson, A., & Pickett, S. (2018). *A critical commentary on follow-up studies and “desistance” theories about transgender and gender-nonconforming children*. *International Journal of Transgenderism*, 19, 212–224.

Tordoff, D.M., et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, *Jama Network Open*, 5(2):e220978 at 1 (2022)

The Trevor Project. (2022). *2022 National Survey on LGBTQ Youth Mental Health*. Available at: <https://www.thetrevorproject.org/survey-2022/> (last visited March 9, 2023).

The Trevor Project and Morning Consult. (2023). *Issues Impacting LGBTQ Youth: Polling Presentation*. Available at https://www.thetrevorproject.org/wp-content/uploads/2023/01/Issues-Impacting-LGBTQ-Youth-MC-Poll_Public-2.pdf (last visited March 9, 2023).

Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020b). *Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults*. *JAMA Psychiatry*, 77(1), 68–76.

Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020a). *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*. *Pediatrics*, 145(2), e20191725.

van der Miesen, A. I. R., Steensma, T. D., de Vries, A. L. C., Bos, H., & Popma, A. (2020). *Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared With Cisgender General Population Peers*. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine*, 66(6), 699–704.

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

JANE DOE 1, et al.,

Plaintiffs,

v.

Case No. 3:23-cv-00230-DJH

WILLIAM C. THORNBURY, JR.,
MD, et al.,

Defendants.

EXPERT REBUTTAL DECLARATION OF DAN H. KARASIC, M.D.

I, Dan H. Karasic, M.D., hereby 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. The information provided regarding my professional background, experiences, publications, and presentations are detailed in my curriculum vitae (“CV”). A true and correct copy of my most up-to-date CV is attached as **Exhibit A**.

4. I am a Professor Emeritus of Psychiatry at the University of California – San Francisco (UCSF) Weill Institute for Neurosciences. I have been on faculty at

UCSF since 1991. I have also had a telepsychiatry private practice since 2020.

5. I received my Doctor of Medicine (M.D.) degree from the Yale Medical School in 1987. In 1991, I completed my residency in psychiatry at the University of California – Los Angeles (UCLA) Neuropsychiatric Institute, and from 1990 to 1991, I was a postdoctoral fellow in a training program in mental health services for persons living with AIDS at UCLA.

6. For over 30 years, I have worked with patients with gender dysphoria.

7. I am a Distinguished Life Fellow of the American Psychiatric Association and the chair of the American Psychiatric Association Workgroup on Gender Dysphoria, as well as the sole author of the chapter on transgender care in the American Psychiatric Press's *Clinical Manual of Cultural Psychiatry*, Second Edition.

8. Over the past 30 years, I have provided care for thousands of transgender patients. For 17 years, I was the psychiatrist for the Dimensions Clinic, for transgender youth ages 12-25 years old, in San Francisco.

9. I previously sat on the Board of Directors of the World Professional Association for Transgender Health (WPATH) and lead author of the Mental Health chapter of WPATH's *Standards of Care for the Health of Gender Diverse and Transgender People* Version 8 (WPATH SOC 8), which are the internationally accepted guidelines designed to promote the health and welfare of transgender, transsexual, and gender variant persons. I was also a co-author of WPATH SOC 7.

10. As a member of the WPATH Global Education Initiative, I helped

develop a specialty certification program in transgender health and helped train over 2,000 health providers. At UCSF, I developed protocols and outcome measures for the Transgender Surgery Program at the UCSF Medical Center. I also served on the Medical Advisory Board for the UCSF Center of Excellence for Transgender Care and co-wrote the mental health section of the original *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* and the revision in 2016.

11. I have worked with the San Francisco Department of Public Health, having helped develop and implement their program for the care of transgender patients and for mental health assessments for gender-affirming surgery. I served on the City and County of San Francisco Human Rights Commission's LGBT Advisory Committee, and I have been an expert consultant for California state agencies and on multiple occasions for the United Nations Development Programme on international issues in transgender care.

12. I have held numerous clinical positions concurrent to my clinical professorship at UCSF. Among these, I served as an attending psychiatrist for San Francisco General Hospital's consultation-liaison service for AIDS care, as an outpatient psychiatrist for HIV-AIDS patients at UCSF, as a psychiatrist for the Transgender Life Care Program and the Dimensions Clinic at Castro Mission Health Center, and the founder and co-lead of the UCSF Alliance Health Project's Transgender Team. In these clinical roles, I specialized in the evaluation and

treatment of transgender, gender dysphoric, and HIV-positive patients. I also regularly provide consultation on challenging cases to psychologists and other psychotherapists working with transgender and gender dysphoric patients. I have been a consultant in transgender care to the California Department of State Hospitals and the California Department of Corrections and Rehabilitation.

13. As part of my psychiatric practice treating individuals diagnosed with gender dysphoria and who receive medical and surgical treatment for that condition, as well as a co-author of the WPATH Standards of Care and UCSF's *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*, I am and must be familiar with additional aspects of medical care for the diagnosis of gender dysphoria, beyond mental health treatment, assessment, and diagnosis.

14. In addition to this work, I have done research on the treatment of depression. I have authored many articles and book chapters and edited the book *Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation*.

15. Since 2018, I have performed over 100 independent medical reviews for the State of California to determine the medical necessity of transgender care in appeals of denial of insurance coverage.

B. Compensation

16. I am being compensated for my work on this matter at a rate of \$400.00

per hour for preparation of declarations and expert reports. I will be compensated \$3,200.00 per day for any deposition testimony or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

C. Previous Testimony

17. Over the past four years, I have given expert testimony at trial or by deposition in the following cases: *C.P. v. Blue Cross Blue Shield of Illinois*, No. 3:20-cv-06145-RJB (W.D. Wash.); *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C.); *Fain v. Crouch*, 3:20-cv-00740 (S.D.W. Va.); *Brandt v. Rutledge*, No. 4:21-cv-00450 (E.D. Ark.); *K.C. et al. vs Individual Members of the Indiana Licensing Board, et al.*, and *Dekker, et al. v. Weida, et al.*, No. 4:22-cv-00325-RH-MAF. To the best of my recollection, I have not given expert testimony at a trial or at a deposition in any other case during this period.

D. Bases for Opinions

18. In preparing this declaration, I have relied on my training and years of research and clinical experience, as set out in my curriculum vitae, and on the materials listed therein, as documented in my curriculum vitae, which is attached hereto as **Exhibit A**.

19. I have also reviewed the materials listed in the bibliography attached hereto as **Exhibit B**. 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.

20. Additionally, I reviewed the text of Kentucky Senate Bill 150, which I understand was enacted over the Governor's veto in March 2023.

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 the subject. I reserve the right to revise and supplement the opinions expressed in this report 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 and issues that may arise in my area of expertise.

22. I reserve the right to revise and supplement the opinions expressed in this report 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 and issues that may arise in my area of expertise. I may also further supplement these opinions in response to information produced by Defendants in discovery and in response to additional information from Defendants' designated experts.

EXPERT REBUTTAL OPINIONS

23. I reviewed the expert reports of Michael K. Laidlaw, M.D., James M. Cantor, PhD, and Stephen B. Levine, M.D., and Geeta Nangia, M.D. I submit this report to respond to points raised in the reports of these experts.

24. The critiques below apply to more than one expert. In this rebuttal report,

I respond to some of the central points made in those reports. I do not address each and every assertion made in those reports that I believe are baseless, misleading, or mischaracterizations of the evidence, as there are many. Instead, my aim is to provide an explanation of the erroneous premises upon which their conclusions are based. As a general matter, the experts for the defense hold views that are outside the mainstream of experts in transgender health and mainstream medical organizations.

THE STATE’S EXPERT WITNESSES’ DESCRIPTION OF GENDER-AFFIRMING CARE FOR ADOLESCENTS WITH GENDER DYSPHORIA BEARS NO RESEMBLANCE TO THE PREVAILING TREATMENT PROTOCOLS

25. The State’s experts offer a description of medical care for adolescents with gender dysphoria that bears no resemblance to the widely accepted protocols for treatment articulated in the WPATH Standards of Care 8 (“WPATH SOC”) and the Endocrine Society Guideline. Throughout their reports, the State’s experts claim that doctors who provide medical interventions to treat gender dysphoria “actively encourage” patients to be transgender, rush to provide medical interventions without psychiatric assessments of patients, disregard other mental health and family issues that could be causing the patient distress, oppose psychotherapy, and fail to inform patients and their families of the risks associated with treatment. (*See, e.g.*, Cantor Report, ¶ 124 (referring to “transition-on-demand”); Levine, ¶ 23 (assuming mental health providers do not address family dynamics and individual psychological development)).

26. Dr. Levine calls this the “affirmation model” of care (Levine, ¶ 46), implying that it is an accepted mode of treatment, but the model he describes is not an accepted model and is completely at odds with the protocols provided in the WPATH SOC and the Endocrine Society Guideline.

27. Dr. Levine also states there is “no consensus or agreed ‘standard of care’ concerning therapeutic approaches to child or adolescent gender dysphoria.” (Levine Report, at Section IV). In fact, there is an international consensus of leaders in providing and researching care for transgender people, which is published as the WPATH Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. The use of the WPATH Standards of Care is supported and/or adopted by, among others, the American Psychiatric Association, the American Psychological Association, the American Medical Association, the American Academy of Pediatrics, by the Federal Bureau of Prisons, and by many insurance companies, and health systems, as well as by Maximus, which administers independent medical reviews for insurance appeals in many states as well as federal appeals. The fact that there are some outlier views, which no matter how loud constitute a minority within the medical and scientific community, does not mean that there is no broad consensus among the larger medical and scientific community about the propriety, safety, and effectiveness of medical care for the treatment of gender dysphoria.

28. Under the prevailing standard of care for instance:

- a. Under the WPATH SOC and Endocrine Society Guideline, appropriate care for transgender youth does not mean steering them in a particular direction, but rather supporting them through their period of exploration of gender expression and increasing self-awareness of their identity. (Coleman, et al., 2022, at 50-51; Ehrensaft, 2017). The WPATH SOC 8 makes clear that “[f]or some youth, obtaining medical treatment is important while for others these steps may not be necessary.” (Coleman, et al., 2022, at 51).
- b. The protocols provide that before any medical interventions are provided to adolescents, a careful mental health assessment should be conducted to ascertain whether the diagnostic criteria for Gender Dysphoria in Adolescents and Adults are met and the appropriateness of such care for the patient. (Coleman, et al., 2022, at S50; Hembree, et al., 2017, at 3877).
- c. The protocols provide that clinicians should ensure that any psychiatric conditions are appropriately addressed and that it is important that mental health care is available to patients before, during, and sometimes after transitioning. (Coleman, et al., 2022 at S256-7; Hembree, et al., 2017, at 3876, 3879.)
- d. The protocols provide for a rigorous informed consent process that includes informing the patient and their parents of side effects of

treatment, including the potential loss of fertility. For hormone therapy, in addition to requiring the parents' informed consent, the adolescent must have "sufficient mental capacity . . . to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent." (Hembree, et al., 2017, at 3878.)

29. In sum, the State's experts create a straw man by providing a false description of care under the prevailing protocols and then attack it. They either misunderstand the prevailing protocols or assume, without basis, that all or most gender clinics disregard them. And while Dr. Levine describes this "model" of care, he acknowledges "I do not know what proportion of practitioners are using" it before also stating that "prompt and thorough affirmation of an asserted transgender identity disregards the principles of child development and family dynamics and is not supported by science." (Levine, ¶ 49). As a clinician who, unlike the State's experts, actively works with a multitude of clinicians providing care to transgender youth and adults, I know firsthand that their characterization of treatment is wholly inconsistent with the prevailing practice. WPATH SOC 8 also requires that practitioners have knowledge of child development and family development and approach the child in a way that "does not favor any identity." (Coleman, et al., 2022).

30. If there are individual doctors who deviate from the accepted protocols and inappropriately provide care that is harmful to patients, medical licensing boards

can address that without denying care to those who have been appropriately assessed and determined to need it. Dr. Levine points to comments by Drs. Laura Edwards-Leeper and Erica Anderson expressing concerns that some children and adolescents are being subjected to puberty blockers and hormonal intervention far too quickly. (See Levine, ¶ 69). These doctors' comments were aimed at improving care, not banning it. After making the comments cited by the State's experts, Dr. Bowers and Dr. Anderson were signatories to a letter from USPATH and WPATH supporting gender-affirming medical care for adolescents with gender dysphoria and opposing legislation like Kentucky's law.¹ And Dr. Edwards-Leeper and Dr. Anderson similarly expressed their full support for gender-affirming care and "disgust" at legislative bans of such care.²

31. It is clear from some of the State's experts' reports that their concern is not about the alleged lack of thorough mental health assessments or access to psychotherapy for patients; it is about opposition to transition-related medical care. (See, e.g., Nangia, ¶ 56; Laidlaw, ¶ 263).

MEDICAL CARE FOR TRANSGENDER ADOLESCENTS IS SAFE AND EFFECTIVE AND IT WOULD BE HARMFUL TO BAN ACCESS TO THIS CARE

32. Gender-affirming medical interventions in accordance with the

¹ United States Professional Association for Transgender Health and World Professional Association for Transgender Health. (2021). Joint Letter from USPATH and WPATH. *Available at* <https://www.wpath.org/media/cms/Documents/Public%20Policies/2021/Joint%20WPATH%20USPATH%20Letter>

WPATH SOC 8 and Endocrine Society Guidelines are widely recognized in the medical community as safe, effective, and medically necessary for many adolescents with gender dysphoria. (See American Academy of Pediatrics, 2018; the American Medical Association, 2021; the Endocrine Society, 2020, the Pediatric Endocrine Society, 2021; the American Psychiatric Association, 2018; the American Psychological Association, 2021; the American Congress of Obstetricians and Gynecologists, 2021; the American Academy of Family Physicians, 2020; WPATH, 2012).

33. Medical treatment for gender dysphoria has been studied for over half a century, and there is substantial evidence that it improves quality of life and measures of mental health. (Aldridge et al., 2020; Almazan, et al., 2021; Baker et al., 2021; Chen, et al., 2023, Murad, et al., 2010; Nobili et al., 2018; Pfafflin & Junge, 1998; T’Sjoen et al. 2019; van de Grift et al., 2017; White Hughto and Reisner, 2016; Wierckx et al., 2014).

34. The State’s experts’ claims that there is no evidence medical transition significantly reduces rates of suicide or suicidality among transgender youth, and Dr. Levine’s claim that treatment may even “increase the risk of suicide,” (Levine, §IX) are patently untrue. A study of transgender youth in the United States showed a decrease in suicidality and increase in reported well-being after treatment with gender affirming hormones. (Allen, et al., 2019). In another study in the United States, treatment with gender affirming hormones in transgender youth was associated with

a substantial reduction in body dissatisfaction, as well as improvement on mental health measures (Kuper, et al., 2020). In a prospective study at Seattle Children’s Gender Clinic of 104 transgender and nonbinary youth ages 13-21 who received puberty blockers or hormones over a 12-month period, treatment with puberty blockers or hormones was associated with 60% less moderate to severe depression and 73% less suicidal ideation, compared to youth not treated (Tordoff, et al. 2022). A Dutch study showed increased suicidality and self-harm in transgender youth compared to cisgender peers before puberty suppression, but transgender youth who were treated with puberty suppression had similar psychological function as cisgender peers. (Van der Miesen, et al., 2020). Data from the Dutch experience with evaluation and care by a multidisciplinary team, using puberty blockers, followed by hormones and surgery when indicated, show that this approach, over many years of follow up, results in high satisfaction, a lack of regret, and mental health outcomes similar to those of a control group that was not transgender. (DeVries, et al., 2014). Zucker, et al., (2010) states about the Dutch studies of treatment of adolescents: “For adolescents recommended for puberty-blocking hormonal therapy, there was . . . evidence of improvement in general psychologic problems at follow-up and certainly no evidence of deterioration in psychological wellbeing.” In a Canadian study of transgender people 16 and older, completing a medical transition was associated with a 62% reduction in suicidal ideation. (Bauer, et al., 2015); *see also* (Green et al., 2021) (finding that access to hormone therapy during adolescence was associated with lower odds of recent

depression and having attempted suicide in the past year); (Turban, et al., 2020) ((finding that access to puberty blockers during adolescence is associated with a decreased lifetime incidence of suicidal ideation among adults); (Achille, et al., 2020) (finding that endocrine intervention was associated with decreased depression and suicidal ideation and improved quality of life for transgender youth); (Costa, et al., 2015) (finding improved psychological function after six months of puberty suppression).

35. The studies on gender-affirming medical care for adolescents with gender dysphoria are consistent with decades of clinical experience of mental health providers across the U.S. and around the world. At professional conferences and other settings in which I interact with colleagues, clinicians report that gender-affirming medical care, for those for whom it is indicated, provides great clinical benefit. In my 30 years of clinical experience treating gender dysphoric patients, including 19 years working with adolescents, I have seen the benefits of gender affirming medical care on my patients' health and well-being. I have seen many patients show improvements in mental health, as well as in performance in school, in social functioning with peers, and in family relationships when they experience relief from gender dysphoria with gender-affirming medical care.

36. To be clear, medical care for a transgender adolescent is not provided simply because someone requests it; it is recommended and provided by health professionals when such care is medically indicated based on an individualized

assessment of a youth's medical needs, and only after obtaining the informed consent of the youth's parents or legal guardians and the informed assent of the youth.

37. Regret rates for gender-affirming medical care are very low. A study of everyone receiving gender-affirming surgery in Sweden over 50 years (1960 to 2010) found a regret rate of 2.2%, declining over the years. There were ten cases of regret from 1960 to 1980, and only five cases of regret total in the last 30 years that were reviewed, from 1981-2010. (Dhejne, et al., 2014). A meta-analysis of 27 studies which reported regret after gender-affirming surgery found that of 7928 people having gender-affirming surgery, the regret rate was 1%. (Bustos, et al., 2021). A study of 209 gender-affirming mastectomies in transmasculine adolescents aged 12-17, performed at Kaiser Permanente Northern California from 2013 to 2020, showed a regret rate of 1%. (Tang, et al 2022). This data is also consistent with my clinical practice. I have had some patients who halted their transition due to challenging personal circumstances—*e.g.*, fear of losing family support—but they still had gender dysphoria. And some came back years later to resume their transition. But in 30 years, I have never seen a patient who had undergone hormone therapy and surgery and later came to identify with their sex assigned at birth and, thus, regretted the treatment and wanted to undo its effects.

38. The overarching goal of treatment is to eliminate the distress of gender dysphoria by aligning an individual patient's body and presentation with their internal sense of self. The denial of medically indicated care to transgender people not only

results in the prolonging of their gender dysphoria, but causes additional distress and poses other health risks, such as depression, posttraumatic stress disorder, and suicidality. In other words, lack of access to gender-affirming care directly contributes to poorer mental health outcomes for transgender people. (Owen-Smith, et al., 2018).

39. For patients for whom gender-affirming medical care is indicated, no alternative treatments have been demonstrated to be effective. The American Psychological Association states that gender identity change efforts provide no benefit and instead do harm. (American Psychological Association, 2021). In 2023, the Substance Abuse and Mental Health Services Administration published a comprehensive review of existing literature on therapeutic efforts to change a child's gender identity or gender expression and found:

No research has demonstrated that gender identity change efforts are effective in altering gender identity; there is also no evidence of any benefits of such practices to children, adolescents, or their families. Recent large, methodologically sound studies have investigated harms associated with gender identity change efforts. These studies indicate that exposure to gender identity change efforts—in childhood, adolescence, and/or adulthood—is associated with harm, including suicidality, suicide attempt, and other negative mental health outcomes such as severe psychological distress.²

40. Accordingly, major medical organizations, such as the American Medical Association, American Psychiatric Association, the Endocrine Society, American College of Obstetricians and Gynecologists, American Urological Association,

² Substance Abuse and Mental Health Services Administration (SAMHSA), *Moving Beyond Change*, Pages 26-27, (2023), available at, <https://store.samhsa.gov/sites/default/files/pep22-03-12-001.pdf> (last visited June 15, 2023).

American College of Physicians, American Association of Clinical Endocrinology, and American Academy of Family Physicians oppose the denial of this medically necessary care and support public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician. (American Medical Association, 2021, 2023; American Psychiatric Association, 2018; Endocrine Society, 2012; American College of Obstetricians and Gynecologists, 2021; American Academy of Family Physicians, 2020). Denial of this appropriate care for transgender adolescents is also opposed by medical professional organizations responsible for the care of youth, including the American Academy of Pediatrics, the Academy of Child and Adolescent Psychiatry, and the Pediatric Endocrine Society. (American Academy of Pediatrics, 2018; American Academy of Child and Adolescent Psychiatry, 2019; Pediatric Endocrine Society, 2021.)

41. For all of the reasons above, there is no basis in medicine or science for a categorical exclusion of gender-affirming care for either adolescents or adults.

THE STATE'S EXPERT WITNESSES OFFER NO ALTERNATIVE EFFECTIVE TREATMENT FOR ADOLESCENTS WITH GENDER DYPHORIA

42. The State's expert witnesses disapprove of existing protocols for treating gender dysphoria in adolescents (and for some of the State's experts, people of any age). As explained above, these opinions are wholly unwarranted. Moreover, the alternative treatments they propose lack any evidence of effectiveness.

43. Dr. Levine claims there is evidence that psychotherapy can sometimes

enable a return to a gender identity that matches sex assigned at birth but offers nothing but anecdotes of “reinvestment” in one’s sex assigned at birth. (Levine, ¶ 45 (“I and other clinicians have witnessed reinvestment in the patient’s biological sex in some individual patients who are undergoing psychotherapy.”)). Efforts were made in the past to assist patients to come to identify with their sex assigned at birth but those efforts have proven to be ineffective and harmful and, thus, treatment with the goal of changing a person’s gender identity are no longer considered ethical. (Coleman, et al., 2012, at 16; American Psychological Association, 2021).

44. Dr. Levine also suggests that as an alternative to medical interventions, health care providers can address gender dysphoria by helping patients understand that there are options beyond sex-stereotyped behaviors. (Levine, ¶ 28). This represents a misunderstanding of gender dysphoria and its diagnosis and treatment. If a patient’s distress relates only to a sense of limitation on behaviors related to gender and they are not experiencing distress about their body, they would not meet the criteria for diagnosis and medical treatment of gender dysphoria.

45. Several of the State’s experts incorrectly point to “watchful waiting” as an alternative treatment approach to the existing treatment paradigms outlined in the WPATH SOC and the Endocrine Society Guideline. (Cantor Report, at ¶¶ 240-244, 255; Levine Report, at ¶¶ 38-39). “Watchful waiting” refers only to prepubertal children, not to adolescents. The term was coined by the same Dutch researchers who pioneered the use of puberty blockers once the same children reached puberty, and

found that puberty blockers, hormones, and later surgery successfully treated gender dysphoria in the same patients once they were of developmental stage for puberty blockers. (Ehrensaft, 2017). The result was that mental health outcomes significantly improved in the adolescents who received transition care in the study. (de Vries, et al., 2014). Other studies have also shown improvement in mental health measures in transgender adolescents with gender-affirming medical treatment. (e.g., van der Miesen, et al., 2020; Kuper, et al., 2020). There is no medical basis for denying these treatments to transgender adolescents, which would serve no purpose other than to subject them to needless suffering and harm, and there is no alternative treatment for transgender adolescents known as “watchful waiting.”

46. The State’s experts rely significantly on the work of Kenneth Zucker in support of “watchful waiting.” But Zucker recognizes the need for medical interventions for gender dysphoria in adolescence and does not suggest that watchful waiting is appropriate for adolescents. (Zucker, et al., 2010). His clinic in Toronto provided puberty blockers and hormone therapy to adolescents with gender dysphoria. (Zucker, et al., 2010). Similarly, the Dutch researchers who coined the term watchful waiting for prepubertal children did the seminal research on medical interventions for those patients whose gender dysphoria persists until adolescence. (de Vries, 2011; Steensma, 2011; de Vries, 2014).

47. Defendants’ experts incorrectly claim that, in the absence of receiving medical care, most transgender youth will naturally “desist” from being transgender.

Though numbers vary by study, desistance is a pre-pubertal phenomenon. Older longitudinal studies included gender nonconforming children who were not transgender due to the broad criteria for the since-abandoned “gender identity disorder in children” diagnosis, and the one large modern American longitudinal study showed very low desistance rates. (Olson, et al, 2022). Moreover, because no medical treatment, let alone irreversible medical and surgical interventions, is used prior to puberty, the persistence and desistance statistics of pre-pubertal children do not inform the decision whether or not to initiate these treatments.

48. To be clear, the desistance studies cited by Defendants’ experts focused on pre-pubertal children. Whatever conclusions can be drawn from them about the likelihood of persistence of gender dysphoria in pre-pubertal children, which again is uncertain given the diagnostic limitations identified above, data indicate that once youth reach the beginning of puberty and identify as transgender, desistance is rare. (DeVries, et al., 2011; Wiepjes, et al., 2018; Brik, et al., 2020; van der Loos, 2022). This data is consistent with clinical experience. In fact, the Amsterdam and Toronto gender centers that published the desistance data on pre-pubertal children referenced above provided medical interventions to youth whose gender dysphoria persisted into adolescence. (Zucker, et al., 2010, DeVries, et al., 2014). In sum, while “watchful waiting” is an approach for prepubertal children followed by some clinicians, it is not an accepted approach used with adolescents.

49. Some of the State’s experts appear to recognize that “watchful waiting”

is a treatment modality for prepubertal children and not adolescents. (*See, e.g.,* Levine, ¶ 39 (“When a pre-adolescent child presents with gender dysphoria, a ‘watchful waiting’ approach seeks to allow for the fluid nature of gender identity in children to naturally evolve.”). Yet they still suggest that “watchful waiting” is an alternative to medical interventions such as hormone therapy for adolescents even though there is no evidentiary support for applying “watchful waiting” to patients once they have started puberty.

50. There is no basis for the State’s experts’ suggestion that providing gender-affirming medical care will cause youth with gender dysphoria who would otherwise desist to, instead, persist. (*See, e.g.,* Levine, ¶¶ 122-125). This claim erroneously relies on the assertion that social transition in prepubertal children can cause their gender dysphoria to persist into adolescence. First, contrary to Dr. Levine’s suggestion, the fact that there is a correlation between social transition prior to puberty and persistence does not establish that social transition *causes* persistence of gender dysphoria. As the Steensma study cited by the State’s experts reported (*see* Steensma, 2013), the intensity of gender dysphoria prior to puberty predicted persistence, and children with more intense dysphoria were more likely to socially transition. Rae, et al., 2019, also found that stronger cross-sex identification in pre-pubertal youth was associated with future social transition. Second, whatever conclusions can be drawn from these desistance studies about the impact of gender affirmation on the persistence rates in prepubertal children, as discussed above, this research does not apply to

adolescents with gender dysphoria, for whom desistance is rare, and the treatments banned by Kentucky's law are not indicated until adolescence.

51. The suggestion that adolescents can just wait until they are 18 years old to get care ignores the harm of not providing the care. Allowing endogenous puberty to advance is not a neutral decision. For many adolescents, the development of secondary sex characteristics that do not match their gender identity can have a severe negative impact on their mental health and can exacerbate lifelong dysphoria because some of those characteristics are impossible to change later through surgeries.

**THE STATE'S EXPERTS DRAW INAPPROPRIATE CONCLUSIONS
FROM THE NUMBERS AND SEX-RATIOS OF GENDER CLINIC
REFERRALS**

52. The State's experts devote many pages to the increase in the numbers of referrals to gender clinics, and changes in sex ratios of patients. (*See, e.g.*, Levine, ¶ 90; Nangia Report, at ¶ 17-20). As an initial matter, in their caricature of doctors pushing medical transition, the State's experts say the field is ignoring and avoiding exploration of these developments. That is not the case. Indeed, the WPATH SOC 8 Adolescent chapter specifically discusses the increase in referrals to gender clinics and the sex ratios of these young patients (Coleman, et al. 2022). But the State's experts draw unsupported conclusions about the rise in number of referrals and changes in sex ratios observed in some clinics. They claim this means adolescents are adopting a transgender identity due to "social contagion," leading them to undergo irreversible medical treatments they later regret. This conclusion is baseless.

53. The rise in numbers of referrals is hardly surprising given the greater awareness on the part of youth and their parents of what gender dysphoria is and that care is available, as well as the significant increase in the number of clinics available to provide care. In addition, the stigma associated with being transgender, while still significant, has lessened in recent years. Coming out to parents and seeking care are options that did not exist for many youth until recently, so an increase in numbers of referrals to gender clinics is not surprising. While there is a documented increase in clinic referrals, the State's experts' exaggerate the increase by making inappropriate comparisons. For example, Dr. Levine refers to surveys of young people and then claims the rates of gender dysphoria and "transition identification" have "increased dramatically, particularly in adolescent populations." (Levine, ¶ 90). Similarly, Dr. Nangia cites surveys of youth who identify as transgender to suggest that these show a "rise of gender dysphoria that [she] observe[s] in [her] own patient population" as well (Nangia Report, at ¶ 17-20). These statements conflate different issues. Transgender is an identity, and only started being asked in the general population in studies published in the last 11 years. There is a great difference between the percentages of people responding to a question of identity with the number of people receiving a diagnosis or care for Gender Dysphoria— fewer than 1 in 1000 people are diagnosed with Gender Dysphoria. Indeed, Defendants' expert Dr. Cantor confirms this point: "Research from youth with formal diagnoses and attending clinics cannot be extrapolated to self-identifying youth and those responding to surveys advertised

on social media sites.” (Cantor Report, at ¶ 65)

54. Put another way, the State’s experts are comparing apples to oranges. An apples to apples comparison of self-identified transgender people over time shows a very different picture. Until the past decade, little data on the number of people identifying as transgender was available. From 2007 to 2009, a question asking whether the respondent identified as transgender was added to a large population-based health survey conducted in Massachusetts, and 0.5% of study participants identified as transgender. (Conron, et al., 2012). Since then, this question was added to large health surveys in other states, and analyses of surveys done in 2014 found that, nationally, 0.5-0.6% of adults identified as transgender, and 0.7% of youth ages 13 to 17 identified as transgender. (Crissman, et al., 2017; Flores, et al., 2016; Herman, et al., 2017). Dr. Levine cites Rider et al. (2018) as reporting that “adolescent girls” received gender dysphoria diagnoses at a rate more than 2x that of “boys.” (Levine, ¶ 29). However, in that study, the question asked was “Do you consider yourself transgender, genderqueer, genderfluid, or unsure about your gender identity?” The larger number does not demonstrate an increasing number of diagnoses of gender dysphoria for any group. Dr. Levine also cites a survey of public high school students disproportionately from large urban school districts, which had 2-9% of “high school students self-identify as transgender or ‘gender non-conforming,’ with a significantly large increase in adolescents claiming ‘nonbinary’ gender identity as well.” (Johns, et al., 2019). The higher number in this survey, done in 2017 more likely reflects the

question and the particular sample than a change over time, versus the lower numbers in Herman et al. (2017), as the time difference was small between the surveys.

55. While increases in numbers and changes in sex ratios of patients referred to some gender clinics have been reported, since the number of patients referred to gender clinics reflect only a small fraction of the people identifying as transgender, these changes may reflect changes in referral patterns to clinics rather than changes in the number of people identifying as transgender.

56. Sex ratios of patients vary from clinic to clinic and over time. When I was the psychiatrist for the Dimensions Clinic for transgender youth in San Francisco from 2003 to 2020, a consistent majority of my patients were assigned female at birth. Other clinics have had more assigned male at birth patients. The rise in numbers and percentage of patients assigned female at birth observed at some clinics in recent years is not surprising given the historical development of the study of gender dysphoria in youth. The first large American study of gender non-conforming youth was the Feminine Boy Study at UCLA. There was significant societal discomfort with and rejection of boys who departed from sex stereotypes—the director of the study referred to them as “sissy boys” in the book resulting from the study—and these boys often experienced bullying from peers. In this context, boys who were perceived to be effeminate were the population brought to psychiatrists by their parents and were the population that was initially studied by researchers. (Green, 1987). Parents were not as concerned about gender non-conforming girls as they were more socially accepted.

There was also less awareness among the general public of the existence of transgender males and that transitioning was an option for individuals assigned female at birth who were experiencing gender dysphoria. The increase in awareness in recent decades made it possible for individuals who ultimately came to identify as transgender men to come out and seek care.

57. There is a social or cultural influence on gender in the sense that social and cultural developments make it more possible for youth struggling with gender dysphoria to access care. But there is no evidence that peer influence determines an individual's gender identity. The State's experts point to Lisa Littman's study discussing what she called "rapid onset gender dysphoria," where parents reported that their children who suddenly identified as transgender boys frequently reported consuming social media about transgender issues and having transgender friends. (*See e.g.*, Cantor ¶ 135; Laidlaw ¶ 209; Levine ¶ 92). While there may be rapid onset parental awareness of a child's transgender status, as is often the case when lesbian and gay youth come out to their parents, that does not mean the gender dysphoria was sudden to the adolescent. In any case, this study does not provide evidence that peers and social media cause individuals to be transgender. As with other marginalized groups, such as lesbian and gay people, it is not unusual to seek out others like you. Nor is it unusual to seek out support and information online. Moreover, the diagnostic criteria for gender dysphoria are rigorous and if there were individuals claiming a transgender identity to fit into a peer group, they would not meet the criteria for a

gender dysphoria diagnosis let alone be deemed to need medical interventions.

**SOME OF THE STATE’S EXPERT WITNESSES QUARREL WITH
THE FIELD OF PSYCHIATRY AND THEIR OPINIONS REFLECT
THEIR LACK OF EXPERIENCE IN THE FIELD**

58. Gender dysphoria is a psychiatric diagnosis. Some of the State’s expert witnesses more generally critique the diagnosis of gender dysphoria for being based on self-reports from patients. Dr. Cantor asserts that “gender identity refers to subjective feelings that cannot be defined, measured, or verified by science.” As such, gender identity cannot be a “valid construct” since it is not “both objectively measurable and falsifiable with objective testing.” (Cantor Report, at ¶ 107). Dr. Laidlaw makes similar points when he states that “gender identity is a psychological concept” and that there are no “imaging, laboratory tests, biopsy of tissue, autopsy of the brain, genetic testing, or other biological markers that can identify gender identity.” (Laidlaw Report, at ¶¶ 19-20); *see also* Levine Report, ¶ 216 (claiming “doctors have no way of ascertaining the truthfulness of the self-report). But clinical interviews with patients are typically used to diagnose other DSM diagnoses and determine treatment. This widely used assessment tool is not unique to gender dysphoria. This process is similar to that of diagnosing other DSM diagnoses, to determine treatment for other disorders. The clinical examination, which includes taking a history of symptoms from a patient, is not only used to determine most psychiatric treatment, but also many medical and pediatric treatments. Moreover, the validity and reliability of DSM-5 diagnoses were assessed and determined in the

process of creating the DSM-5. It is surprising to hear any medical professional dismiss the importance of taking a good history from a patient. Even medical disorders that rely on blood tests and imaging for a definitive diagnosis rely first on taking a history to know which tests to order. And treatment of many DSM diagnoses is considered medically necessary and covered by Medicaid and other insurance programs.

59. With respect to gender dysphoria in particular, WPATH's SOC 8 sets forth criteria for assessing adolescents that include a "comprehensive biopsychosocial assessment including relevant mental health and medical professionals" and that "[m]ental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally." (Coleman, et al., 2022).

**THE STATE'S EXPERT WITNESSES' ATTEMPTS TO DISCREDIT THE
WPATH STANDARDS OF CARE AND ALL OF THE PROFESSIONAL
GROUPS THAT ACCEPT THEM ARE BASELESS**

60. The State's expert witnesses characterize WPATH (and USPATH) as ideological, non-scientific, advocacy organizations, open to transgender activists outside of the health field. (Laidlaw, ¶¶ 174-175; Levine, ¶¶ 60-68). Many WPATH and USPATH members are academics who publish in peer-reviewed journals. Many are academic leaders in endocrinology, internal medicine, plastic surgery, urology, psychiatry, psychology, and other disciplines of the health sciences. WPATH restricts

its full membership to those with professional credentials and most members are licensed clinicians. The fact that WPATH engages in advocacy on behalf of its patient population for access to beneficial care is typical of medical associations. For example, the American Psychiatric Association advocates for a wide range of public policy changes to improve access to mental health care, *e.g.*, for migrants and for incarcerated people.³

61. Dr. Levine asserts “[i]n my experience some current members of WPATH have little ongoing experience with the mentally ill.” (Levine, ¶ 68). I do not know what he is basing this on since he has not been involved with WPATH in two decades. Mental health providers make up the largest percentage of WPATH’s membership. I have been involved with WPATH for many years and have 35 years of experience treating people with mental illnesses. And there are many other experienced mental health professionals in WPATH. These mental health professionals are licensed and regulated by state licensing boards, and most provide care to both cisgender and transgender clients—including those with serious mental illness. In my more than

³ See American Psychiatric Association. (2019). Position Statement on the Care of Medically Vulnerable Migrants in the United States. *Available at* <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Position-Care-of-Medically-Vulnerable-Migrants-in-the-US.pdf>; American Psychiatric Association. (2016). Position Statement on Treatment of Substance Use Disorders in the Criminal Justice System. *Available at* <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Position-2016-Substance-Use-Disorders-in-the-Criminal-Justice-System.pdf>; *see generally* American Psychiatric Association Policy Finder, *available at* <https://www.psychiatry.org/home/policy-finder>.

three decades of experience, I have provided training and instruction to thousands of healthcare providers across the United States, as well as at UCSF. It has not been my experience that practitioners in this field are unqualified. To the contrary, they are highly specialized professionals living up to their calling of providing the best care possible for their patients.

62. The State's expert witnesses also argue that dissenting views are not tolerated in WPATH. (Levine, ¶ 63). Yet, as a number of them noted, Dr. Marci Bowers has expressed some criticism about how some in the field are practicing, and she is the president of WPATH. I have attended several WPATH conferences since 2001, and have been a member of the Scientific Committees that have reviewed abstract submissions for the conferences, and the diversity of views presented and discussed has always been notable. For example, as chair of the Scientific Committee for the 2017 USPATH conference, I helped organize a panel of therapists and trainees who had themselves detransitioned, and the presentations and discussion were well-received by attendees.

**THE STATE'S EXPERT WITNESSES MISREPRESENT THE
AVAILABILITY OF TREATMENT FOR ADOLESCENTS WITH GENDER
DYSPHORIA IN EUROPE**

63. Dr. Cantor falsely asserts that a number of countries "endorse psychotherapy as the treatment choice for minors, with medical interventions representing a method of last resort, if permitted at all." He goes on, "[t]hese range from medical advisories to outright bans on the medical transition of minors." (Cantor,

¶ 16). In fact, none of the countries he discussed— U.K., Finland, France, Norway, or Sweden—has a law banning transition care to minors and in none of these countries is such care for minors unavailable.

64. In reviewing the international health care consensus regarding gender-affirming care, Dr. Cantor refers to an interim report on care of transgender youth in the United Kingdom’s National Health System which is being compiled by Dr. Hilary Cass. The interim report states that the final report will synthesize published evidence with expert opinion and stakeholder input. Notably, the interim report recommends increasing the number of health providers, shortening wait times, and increasing the number of centers across the country providing care to transgender youth. Far from recommending that medical treatments for transgender adolescents be halted or banned, the report recommends that providers follow the Endocrine Society clinical practice guidelines.

65. Swedish and Finnish national health authorities, which Dr. Cantor also references, have recommended caution and more research but have not banned care for transgender youth. In these countries, transition care for adults and youth is fully paid for by the national health system of each country.

66. There remains strong international support for the continued provision of gender-affirming medical care. Experts from the around the world have collaborated on the new WPATH Standards of Care Version 8. I was chapter lead of the Mental Health chapter of this version, and the authors of that chapter include psychiatrists

who are leaders of transgender health programs in Belgium, Sweden, and Turkey. There is broad agreement in philosophy of care, including support for gender-affirming care and opposition to conversion therapy.

67. I have only had a few patients over the years who have been forced to detransition, because of incarceration or institutionalization, or other circumstances, and results have been uniformly disastrous, with suicide and self-harm attempts, depression, and deterioration of functioning. Some of my patients forced to detransition were receiving intensive mental health care at the time, on psychiatric wards. But no amount of psychotherapy could counter the deleterious effects of forced detransition and the withholding of needed gender-affirming medical and surgical care.

ADDITIONAL POINTS IN RESPONSE TO THE STATE’S EXPERTS

Dr. Stephen Levine

68. Stephen Levine, MD, was an editor of Standards of Care 5 (“SOC 5”) of the Harry Benjamin Gender Dysphoria Association (the precursor to WPATH), which were released in 1998. After widespread criticism of the SOC 5, it was replaced by the SOC 6 in just three years. By contrast, the SOC 6 (published in 2001) SOC 7 (published in 2012) were each in use for approximately 10 years. Dr. Levine was critical of the changes in transgender care in 1998 and has been a critic of modern transgender care since. His involvement in transgender health in recent years has centered on the denial of care to transgender people through his role providing testimony with respect to

prison systems.

69. Dr. Levine quotes the Endocrine Society repeatedly in his discussion of “biological sex.” (Levine, ¶¶ 15-19). However, he omits that the Endocrine Society states, “the terms biological sex and biological male and female are imprecise and should be avoided.” (Hembree, et al. 2017).

70. Dr. Levine states, “Contrary to assertions and hopes that medicine and society can fulfill the aspiration of the individual adopting a transgender identity to become ‘a complete man’ or ‘a complete woman,’ this is not biologically attainable,” because, for instance, a transgender man will never be able to “produce sperm and father children.” (Levine, ¶ 23). For one, transgender individuals may find other ways to build families, as do other individuals who need medical assistance with reproduction or choose to adopt. Reproductive capacity is not what makes a person a man or a woman, and we do not describe others as less of a man or woman for needing assistance with family building or choosing not to raise children. For another, the goal of health practitioners in this field is not to facilitate “trans individual to become ‘a complete man’ or ‘a complete woman.’” The goal of practitioners in this field is to treat the clinically significant distress of Gender Dysphoria and to improve the quality of life of those living with gender dysphoria.

71. Dr. Levine discusses providing psychotherapy to minors to “possibly address underlying developmental adversities that enable the minor to identify as a transgendered person.” (Levine, ¶ 45) This statement conflicts with his prior statement

that, “To my knowledge, there is no evidence beyond anecdotal reports that psychotherapy can enable a return to male identification for genetically male boys, adolescents, and men, or return to female identification for genetically female girls, adolescents, and women.” (*Id.*) There is no evidence that being transgender is caused by any underlying developmental or psychological “adversities” or conditions, nor is there any evidence that psychotherapy can “cure” a person from being transgender. To the contrary, all available evidence suggests that therapeutic attempts to alter a person’s transgender identity are ineffective and harmful, and such efforts have been rejected as unethical and inappropriate by medical and mental health organizations.

72. In paragraph 67 of his report, Dr. Levine states that “In 2010 the WPATH Board of Directors issued a statement advocating that incongruence between sex and felt gender identity should cease to be identified in the DSM as a pathology. This position was debated but not adopted by the (much larger) American Psychiatric Association.” This is patently false. In fact, I was a member of WPATH’s committee advising the American Psychiatric Association on diagnostic revision for DSM-5 (after editing a book on the subject). WPATH stated that transgender identity should not be a pathology but that the diagnosis should focus on the distress of gender dysphoria and be named Gender Dysphoria. The American Psychiatric Association agreed with WPATH and replaced the Gender Identity Disorder diagnosis with Gender Dysphoria. Indeed, the American Psychiatric Association’s own “Guide for Working With Transgender and Gender Nonconforming Patients” states that “[w]ith

the publication of DSM–5 in 2013, ‘gender identity disorder’ was eliminated and replaced with ‘gender dysphoria.’ This change further focused the diagnosis on the gender identity-related distress that some transgender people experience (and for which they may seek psychiatric, medical, and surgical treatments) rather than on transgender individuals or identities themselves.” (Yarbrough, et al., 2017). It goes on to state that “[t]he presence of gender variance is not the pathology but dysphoria is from the distress caused by the body and mind not aligning and/or societal marginalization of gender-variant people. *Id.*

73. Regarding Dr. Levine and others’ use of Dhejne et al., 2011 for the proposition that gender-affirming is not effective (*e.g.*, Levine Report, ¶162; Laidlaw Report, ¶203; Cantor Report, ¶137) Dr. Dhejne has specifically cited Dr. Levine as someone who misinterprets her study. “The findings have been used to argue that gender-affirming treatment should be stopped since it could be dangerous (Levine, 2016) ... Despite the paper clearly stating that the study was not designed to evaluate whether or not gender-affirming is beneficial, it has been interpreted as such.” (Dhejne, 2017). Indeed, the Dhejne et al. study explicitly states that the study cannot be used to make any conclusions about the outcome of surgery. (Dhejne, et al., 2011). And since 2011, Dr. Dhejne has repeatedly stated that interpretations like the above are incorrect. Dr. Dhejne compared morbidity and mortality statistics from a national database of transgender people with those in the general Swedish population, and only made comparisons between these groups, not before and after surgery, or transgender

people with surgery and without surgery, or “year 7” with prior years. (e.g., Dhejne, 2017). Despite these warnings the State’s experts continue to improperly use Dr. Dhejne’s study. Moreover, the actual data from Dhejne’s study shows there were ten suicides in the national morbidity and mortality database of transgender people over a period of thirty years compared to five suicides in the general population during that same period.

74. Nor is it true, as Dr. Cantor contends, that a “very large dataset from the U.K.” showed that youth referred to the clinic for evaluation and treatment for gender dysphoria “committed suicide at a rate of five times that of the general population. (Cantor, ¶ 147) (citing Biggs 2022). That U.K. data is based on four probable suicides in transgender youth, including two who were on the waiting list for care and two who were receiving care.

75. The State’s experts also focus on the two suicides that occurred during the Chen study, with one expert claiming they “show the inherent danger of gender affirmative therapy found in the Dhejne study.” (Laidlaw, ¶ 204). While any suicide is very concerning, these claims are simply untrue. There is zero evidence that the two suicides were due to receiving gender affirming care and as other studies have found, medical care significant reduces suicidality. *See, e.g.*, (Kaltiala, et al., 2020) (finding that dramatically fewer youth (35% versus 4%) needed treatment for suicidality after starting hormone medication).

76. The State’s expert witnesses point to elevated rates of mental health

problems and substance use in the transgender community, suggesting that being transgender is the cause of these negative outcomes and, thus, something doctors should try to prevent. (*See e.g.*, Levine, ¶¶ 145-146). As discussed above, being transgender is not something doctors can prevent. And these comments disregard the significant stigma transgender people continue to face, and stigma is a well-documented risk factor for mental health and substance use issues.

77. Apparently in support of the unattainable goal of trying to deter people from being transgender, Dr. Levine makes the wholly unsupported statements that transgender people often cannot find romantic relationships, have “diminished” opportunities to find romantic and intimate relationships and “will soon learn that many of their dates are looking for exotic sexual experiences rather than genuinely loving relationships. (Levine, ¶ 194). That may be his own view of transgender people (indeed, he cites only sources that he authored), but it is not at all consistent with clinical experience, including my own. Many transgender people lead fulfilling lives, form romantic relationships, have families, and have close relationships with friends and extended family.

78. Dr. Levine states that the WPATH SOC 8 does not discuss “how to help those who have detransitioned on their own accord.” (Levine Report, at ¶118) WPATH SOC 8 explicitly “recommend[s] health care professionals assessing adults who wish to detransition and seek gender-related hormone intervention, surgical intervention, or both, utilize a comprehensive multidisciplinary assessment that will

include additional viewpoints from experienced health care professional in transgender health and that considers, together with the individual, the role of social transition as part of the assessment process” and explicitly discusses detransition. (Coleman, et al., 2022).

79. In addition to WPATH SOC 8, WPATH has provided education on working with detransitioners, including a session I helped organized at USPATH in 2017 and trainings by WPATH’s Global Education Initiative. As clinicians, we did not anticipate drafting protocols for forced detransition that might be caused by state laws like Kentucky’s. However, WPATH SOC 8 warns against the involuntary cessation of hormones, e.g., in hospitals and other institutional settings. (Coleman, et al 2022).

80. Dr. Levine states “engaging in social transition starts a juvenile on a ‘conveyor belt’ path that almost inevitably leads to the administration of puberty blockers, which in turn almost inevitably leads to the administration of cross-sex hormones.” (Levine Report, at ¶126). A study which Dr. Levine fails to cite has found this not to be true. The study authors found that gender identification did not meaningfully differ before and after social transition. (Rae, et al., 2019).

Dr. James Cantor

81. Dr. Cantor’s report indicates that his work at the University of Toronto from 1998 to 2018 was limited to its adult forensic program, that is, Dr. Cantor worked with people with paraphilias,² and in particular with pedophiles. Paraphilias are persistent

and recurrent sexual interests, urges, fantasies, or behaviors of marked intensity involving objects, activities, or even situations that are atypical in nature. Being transgender is not a paraphilic disorder. Dr. Cantor is well known for this work, but not for his work with transgender people. In testimony in *Eknes-Tucker v. Marshall*, Dr. Cantor stated that he had not personally diagnosed any child or adolescent with gender dysphoria, and that he had personally never treated any child or adolescent for gender dysphoria.

82. Dr. Cantor focuses on desistance rates of prepubertal children brought into clinics in Toronto and Amsterdam. (Cantor, ¶ 132) However, given that these prior longitudinal studies included gender nonconforming children who were not transgender due to the broad criteria for the since-abandoned “gender identity disorder in children” diagnosis, or who did not qualify even for the gender identity disorder in children diagnosis, these studies shed little light into questions of persistence and desistance of gender dysphoria in pre-pubertal children. In fact, a more recent study, which is the only large American prospective study that has been published in the past 35 years, showed much lower desistance rates (Olson, et al., 2022). Specifically, only 2.5% of the youth studied identified with their sex assigned at birth.⁴

83. In any event, longitudinal studies show that gender dysphoria in

⁴ Of these, youth with cisgender identities were more common among youth whose initial social transition occurred before age 6 years; their retransitions often occurred before age 10 years. And, again, no medical treatment is recommended for any transgender person prior to the onset of puberty.

adolescence usually persists (DeVries, et al., 2011). And no medical treatment, let alone irreversible medical interventions, is used prior to puberty. Even in the clinics with higher desistance rates for *pre-pubertal* children upon which Dr. Cantor relies, puberty blockers and hormones were used when gender dysphoria persisted after the onset of puberty. In sum, the desistance statistics of *pre-pubertal* children do not inform the decision whether or not to initiate these treatments in adolescents and adults.

84. Dr. Cantor references a study by Kaltiala et al. in 2020 claiming that the authors concluded from the study that “the youth who were functioning well after transition were those who were functioning well before transition, and those who were functioning poorly before transition continued to function poorly after transition.” (Cantor Report, at ¶ 22). In fact, in the Kaltiala et al. study, of the 52 youth studied, 54% needed treatment for depression before initiation of gender-affirming hormones, versus 15% needing treatment for depression after initiation of gender-affirming hormones. In the study, 48% of the trans youth needed treatment for anxiety before starting hormones, versus 15% after starting hormones. And 35% of the trans youth needed treatment for suicidality/self-harm before starting hormones, versus 4% after initiation of gender affirming hormones (Kaltiala, et al., 2020).

85. Dr. Cantor states that the study by Kuper, et al. 2020 did not show benefit from treatment. This statement is misleading at best. Dr. Cantor says the Kuper study shows increased suicidal ideation and attempts after treatment compared with before

treatment—but the measurement period for the numbers were 1-3 months before the study versus 11-18 months after the study, explaining the higher numbers in the second, longer period. This study does not show that treatment increased the patients’ rates of suicidality or that they did not benefit from treatment. The article concludes, “Youth reported large improvements in body dissatisfaction ($P < .001$), small to moderate improvements in self-report of depressive symptoms ($P < .001$), and small improvements in total anxiety symptoms ($P < .01$).” Dr. Cantor further states that the study by Achille et al. does not show that those studied benefitted from endocrine treatment. (Cantor, ¶ 195) Again, Cantor’s characterization of this study’s conclusion is misleading. The results of the paper actually show that, “Mean depression scores and suicidal ideation decreased over time while mean quality of life scores improved over time. When controlling for psychiatric medications and engagement in counseling, regression analysis suggested improvement with endocrine intervention. This reached significance in male-to-female participants.”

86. After lengthy criticism of literature supporting gender affirming care, which Dr. Cantor distorts through cherry-picking, Dr. Cantor uses Diaz and Bailey (2023) to draw the conclusion that the body of research supporting gender-affirming care cannot be applied to current transgender youth. (Cantor, ¶135) Diaz and Bailey’s paper has received extensive criticism, including that its first author is anonymous and did not seek the human subjects review that is a standard requirement, and that the data was obtained from parents of trans people visiting a site that is named after the

phenomenon the paper purports to examine—a site that opposes gender affirming care. The second author, Dr. Bailey, is listed as an editorial board member of the journal that published the paper, despite the fact that Bailey’s institutional review board at Northwestern University refused to approve the research protocol. Ultimately, Springer Nature, publisher of the journal, retracted the article, reportedly due to ethical concerns, including lack of informed consent.⁵

87. Dr. Cantor refers to systematic reviews of the literature of gender affirming care for minors, as does Dr. Levine. It is important to put GRADE scores of systematic reviews in context. Chong, et al., 2023 found that only 36% of national guidelines for care were based on strong or moderate GRADE scores. Recommendations were often based on a comparison with alternatives; there is no evidence base to support conversion therapy or other psychotherapeutic interventions as an alternative for those who need gender-affirming medical treatment.

88. In one large study of systematic reviews, only 5.6% of all medical interventions, and 0.0% of all endocrine interventions had a high GRADE score. Most medical interventions had low or very low GRADE scores. (Howick, et al 2022).

⁵ Diaz S, Michael Bailey J. Retraction Note: Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases. *Arch Sex Behav.* 2023 Jun 14. doi: 10.1007/s10508-023-02635-1. Epub ahead of print. PMID: 37314659; *see also*, Ellie Kincaid, *After backlash, publisher to retract article that surveyed parents of children with gender dysphoria, says co-author*, (May 24, 2023), <https://retractionwatch.com/2023/05/24/after-backlash-publisher-to-retract-article-that-surveyed-parents-of-children-with-gender-dysphoria-says-co-author>.

89. In other studies, including one of all systematic reviews in the Cochrane database published over an 18-month period, only a small percentage of systematic reviews of medical interventions had a high GRADE score; for a majority of systematic reviews of medical interventions, GRADE scores were low or very low. (Fleming et al., 2016, Howick, et al., 2020). In a study of systematic reviews of interventions in anesthesiology, critical care medicine, and emergency medicine, only 10% had high GRADE scores, but banning the practice of anesthesiology, critical care medicine, and emergency medicine has not been contemplated (Conway, et al, 2017). For complex interventions, for which gender affirming care certainly qualifies, no high GRADE scores were found for systematic reviews of any complex intervention. (Movsisyan, et al., 2016).

90. Dr. Levine similarly misinterprets GRADE scores as an indication that a given medical treatment is neither effective nor safe. This is not the case. No publication has ever equated a very low GRADE score with, as Dr. Levine contends, “a high likelihood that the patient will not experience the hypothesized benefits of the treatment.” (Levine Decl., ¶140) What the source Dr. Levine cites for that proposition actually says is that, especially where high-quality randomized control trials are not available or feasible, low-quality evidence can nonetheless lead to strong medical recommendations. (Balslem et al., 2011).

91. In short, the State’s experts use systematic studies in ways they are not intended to be used. If only medical interventions with high GRADE scores were

permitted by law, most medical interventions and all complex interventions, would be banned.

Dr. Michael Laidlaw and Dr. Geeta Nangia

92. Dr. Laidlaw is an endocrinologist for adults, with no experience or specialized training as a mental health provider, no apparent experience working with pediatric patients, and no apparent experience providing or researching medical treatment for gender dysphoria. Notwithstanding his lack of experience and that he has not met any of the plaintiffs or reviewed any medical or mental health records, Dr. Laidlaw makes clinical recommendations on the course of treatment for the plaintiffs, including their mental health. (Laidlaw Report, at ¶¶ 234-262). This is highly unusual and unethical.

93. Defendants’ experts opine at length about the “experimental nature” of gender-affirming care. Dr. Nangia also states “there is remarkable controversy and debate over [the WPATH] recommendations and the data that supports them. (Nangia Report, ¶ 131). As explained in detail above, gender-affirming medical interventions are widely recognized in the medical community as safe, effective, and medically necessary for many adolescents with gender dysphoria..

94. One misperception is that hormone therapy is experimental because it is not FDA-approved for the specific application of treating Gender Dysphoria. (Laidlaw Report, ¶¶ 72-76; Levine Report, ¶ 174; Nangia Report, ¶ 41) Medications very commonly are prescribed for off-label uses. All gender-affirming hormone treatments

are approved for treatment of other conditions and have been used to treat those conditions, as well as for gender-affirming care, for many years, supporting their safety and efficacy. The U.S. Department of Health and Human Services Agency for Healthcare Research and Quality states, “[Off-label prescribing] is legal and common. In fact, one in five prescriptions written today are for off-label use.

95. Dr. Laidlaw misleadingly cites a review of psychiatric side effects of anabolic steroid abuse in cisgender men (Hall, et al., 2005) to make the claim that testosterone use is dangerous to mental health. (Laidlaw, ¶ 137) In Pope et al. 2000, which was one study cited in the Hall, 2005 paper, even 600mg/week of testosterone usually didn’t cause psychiatric symptoms. This dose is several times the typical dose that would be prescribed to transgender adolescents to treat gender dysphoria. (Pope, et al., 2000).

96. When used at proper doses in transgender males, testosterone is safe and well-tolerated, usually without clinically significant mental health complications. A prospective study showed improved psychological functioning on multiple domains on initiation of testosterone in transgender males. (Keo-Meier, et al., 2015)

CONCLUSION

97. Kentucky’s categorical exclusion of gender-affirming medical care for transgender adolescents is contrary to widely accepted medical protocols for the treatment of transgender people with gender dysphoria that are recognized by major medical and mental health professional associations in the United States.

98. Decades of medical research and clinical experience have demonstrated that the medical treatments Kentucky seeks to bar are safe, effective, and medically necessary to relieve gender dysphoria for transgender people. Any conclusion otherwise is not supported by medical evidence or consensus.

99. Denying gender-affirming medical care to transgender people for whom it is medically indicated puts them at risk of significant harm to their health and wellbeing, including heightened risk of depression and suicidality.

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

Executed this 16th day of June 2023.

A handwritten signature in black ink, appearing to read 'D. Karasic', written over a horizontal line.

Dan H. Karasic, M.D.

EXHIBIT A

University of California, San Francisco
CURRICULUM VITAE

Name: Dan H. Karasic, MD

Position: Professor Emeritus
Psychiatry
School of Medicine

Voice: 415-935-1511

Fax: 888-232-9336

EDUCATION

1978 - 1982	Occidental College, Los Angeles	A.B.; Summa Cum Laude	Biology
1982 - 1987	Yale University School of Medicine	M.D.	Medicine
1987 - 1988	University of California, Los Angeles	Intern	Medicine, Psychiatry, and Neurology
1988 - 1991	University of California, Los Angeles; Neuropsychiatric Institute	Resident	Psychiatry
1990 - 1991	University of California, Los Angeles; Department of Sociology	Postdoctoral Fellow	Training Program in Mental Health Services for Persons with AIDS

LICENSES, CERTIFICATION

1990	Medical Licensure, California, License Number G65105
1990	Drug Enforcement Administration Registration Number BK1765354
1993	American Board of Psychiatry and Neurology, Board Certified in Psychiatry

PRINCIPAL POSITIONS HELD

1991 - 1993	University of California, San Francisco	Health Sciences Psychiatry Clinical Instructor
1993 - 1999	University of California, San Francisco	Health Sciences Psychiatry Assistant Clinical Professor

1999 - 2005	University of California, San Francisco	Health Sciences Psychiatry Associate Clinical Professor
2005 - present	University of California, San Francisco	Health Sciences Psychiatry Clinical Professor

OTHER POSITIONS HELD CONCURRENTLY

1980 - 1980	Associated Western Universities / U.S. Department of Energy	Honors Undergraduate Research Fellow	UCLA Medicine
1981 - 1981	University of California, Los Angeles; Medicine American Heart Association, California Affiliate	Summer Student Research Fellow	UCLA
1986 - 1987	Yale University School of Medicine; American Heart Association, Connecticut Affiliate	Medical Student Research Fellow	Psychiatry
1990 - 1991	University of California, Los Angeles	Postdoctoral	Sociology Fellow
1991 - 2001	SFGH Consultation-Liaison Service; AIDS Care	Attending Psychiatrist	Psychiatry
1991 - 2001	AIDS Consultation-Liaison Medical Student Elective	Course Director	Psychiatry
1991 - present	UCSF Positive Health Program at San General Hospital (Ward 86)	HIV/AIDS Outpatient Psychiatrist	Psychiatry Francisco
1991 - present	UCSF AHP (AIDS Health Project/Alliance Health Project)	HIV/AIDS Outpatient Psychiatrist	Psychiatry
1994 - 2002	St. Mary's Medical Center CARE Unit. The CARE Unit specializes in the care of patients with AIDS dementia.	Consultant	Psychiatry
2001 - 2010	Depression and Antiretroviral Adherence Study (The H.O.M.E. study: Health Outcomes of Mood Enhancement)	Clinical Director	Psychiatry and Medicine
2003 - 2020	Transgender Life Care Program and Clinic, Castro Mission Health	Psychiatrist Clinic Center	Dimensions Dimensions
2013 - 2020	UCSF Alliance Health Project, Co-lead, Transgender Team	Co-Lead and Psychiatrist	Psychiatry

HONORS AND AWARDS

1981	Phi Beta Kappa Honor Society	Phi Beta Kappa
------	------------------------------	----------------

1990	NIMH Postdoctoral Fellowship in Health Services for People with AIDS (1990-1991)	National Institute of Mental Health Mental Health Services for People with AIDS (1990-1991)
2001	Lesbian Gay Bisexual Transgender Leadership Award, LGBT Task Force of the Cultural Competence and Diversity Program	SFGH Department of Psychiatry
2006	Distinguished Fellow	American Psychiatric Association
2012	Chancellor's Award for Leadership in LGBT Health	UCSF
2023	Alumni Seal Award for Achievement	Occidental College Professional

MEMBERSHIPS

- 1992 - present Northern California Psychiatric Society
- 1992 - present American Psychiatric Association
- 2000 - 2019 Bay Area Gender Associates (an organization of psychotherapists working with transgendered clients)
- 2001 - present World Professional Association for Transgender Health

SERVICE TO PROFESSIONAL ORGANIZATIONS

- 1981 - 1982 The Occidental News Editor
- 1984 - 1985 Yale University School of Medicine Class President
- 1989 - 1991 Kaposi's Sarcoma Group, AIDS Project Los Angeles Volunteer Facilitator
- 1992 - 1996 Early Career Psychiatrist Committee, Association of Gay and Lesbian Psychiatrists Chair and
- 1992 - 1996 Board of Directors, Association of Gay and Lesbian Psychiatrists Member Psychiatrists
- 1993 - 1993 Local Arrangements Committee, Association of Gay and Lesbian Psychiatrists Chair Lesbian Psychiatrists
- 1994 - 1995 Educational Program, Association of Gay and Lesbian Psychiatrists, 1995 Annual Meeting Director Psychiatrists,
- 1994 - 1998 Board of Directors, BAY Positives Member
- 1994 - present Committee on Lesbian, Gay, Bisexual and Transgender Issues, Northern California Psychiatric Society Member
- 1995 - 1997 Board of Directors, Bay Area Young Positives. BAY President

Positives is the nation's first community-based organization providing psychosocial and recreational services to HIV-positive youth

1995 - 1997	Executive Committee, Bay Area Young Positives.	Chair
1996 - 2004	Committee on Lesbian, Gay, Bisexual and Transgender Northern California Psychiatric Society	Chair Issues,
1998 - 2002	City of San Francisco Human Rights Commission, Gay Bisexual Transgender Advisory Committee	Member Lesbian,
2000 - 2004	Association of Gay and Lesbian Psychiatrists. the organization's educational programs	Vice President Responsible for
2004 - 2005	Association of Gay and Lesbian Psychiatrists	President-elect
2005 - 2007	Caucus of Lesbian, Gay, and Bisexual Psychiatrists of the Chair	American Psychiatric Association
2005 - 2007	Association of Gay and Lesbian Psychiatrists	President
2007 - 2009	Association of Gay and Lesbian Psychiatrists	Immediate Past President
2009 - 2010	Consensus Committee for Revision of the Sexual and Gender Identity Disorders for DSM-V, GID of Adults subcommittee. (Wrote WPATH recommendations as advisory body to the APA DSM V Committee for the Sexual and Gender Identity Disorders chapter revision.)	Member
2010 - 2011	Scientific Committee, 2011 WPATH Biennial Symposium,	Member Atlanta
2010 -2022	World Professional Association for Transgender Care Standards of Care Workgroup and Committee (writing seventh and eighth revisions of the WPATH Standards of Care, which is used internationally for transgender care.)	Member
2010 - 2018	ICD 11 Advisory Committee, World Professional Association for Transgender Health	Member
2012 - 2014	Psychiatry and Diagnosis Track Co-chair, Scientific 2014 WPATH Biennial Symposium, Bangkok	Member Committee,
2014 - 2016	Scientific Committee, 2016 WPATH Biennial Symposium,	Member Amsterdam
2014 - 2018	Board of Directors (elected to 4 year term), World Association for Transgender Health	Member Professional
2014 - 2018	Public Policy Committee, World Professional Association for Transgender Health	Chair for Transgender
2014 - 2018	WPATH Global Education Initiative: Training providers and specialty certification in transgender health	Trainer and Steering Committee Member

2014 - 2016 American Psychiatric Association Workgroup on Gender Member Dysphoria
 2016 - present American Psychiatric Association Workgroup on Gender Chair Dysphoria
 2016 USPATH: Inaugural WPATH U.S. Conference, Los Angeles, 2017 Conference Chair

SERVICE TO PROFESSIONAL PUBLICATIONS

2011 - present Journal of Sexual Medicine, reviewer
 2014 - present International Journal of Transgenderism, reviewer
 2016 - present LGBT Health, reviewer

INVITED PRESENTATIONS - INTERNATIONAL

2009 World Professional Association for Transgender Health, Oslo, Norway Plenary Session Speaker
 2009 World Professional Association for Transgender Health, Oslo, Norway Symposium Speaker
 2009 Karolinska Institutet, Stockholm Sweden Invited Lecturer
 2012 Cuban National Center for Sex Education (CENESEX), Cuba Invited Speaker Havana,
 2013 Swedish Gender Clinics Annual Meeting, Stockholm, Sweden Keynote Speaker
 2013 Conference on International Issues in Transgender care, United Nations Development Programme - The Lancet, Beijing, China Expert Consultant
 2014 World Professional Association for Transgender Health, Thailand Track Chair Bangkok,
 2014 World Professional Association for Transgender Health, Bangkok, Thailand Invited Speaker
 2014 World Professional Association for Transgender Health, Bangkok, Thailand Invited Speaker
 2015 European Professional Association for Transgender Health, Ghent, Belgium Invited Speaker Health,
 2015 European Professional Association for Transgender Health, Ghent, Belgium Symposium Chair
 2015 Israeli Center for Human Sexuality and Gender Identity, Tel Aviv Invited Speaker
 2016 World Professional Association for Transgender Health, Amsterdam Symposium Chair
 2016 World Professional Association for Transgender Health, Amsterdam Invited Speaker
 2016 World Professional Association for Transgender Health, Invited Speaker

Amsterdam 2017
 Brazil Professional
 Association for Transgender
 Health, Sao Paulo

2017 Vietnam- United Nations Development Programme Asia
 Transgender Health Conference, Hanoi

2018 United Nations Development Programme Asia Conference on
 Transgender Health and Human Rights, Bangkok

2018 World Professional Association for Transgender Health, Invited Speaker Buenos
 Aires

2021 Manitoba Psychiatric Association, Keynote Speaker

INVITED PRESENTATIONS - NATIONAL

1990 Being Alive Medical Update, Century Cable Television Televised Lecturer

1992 Institute on Hospital and Community Psychiatry, Toronto Symposium Speaker

1992 Academy of Psychosomatic Medicine Annual Meeting, San Diego Symposium
 Speaker

1994 American Psychiatric Association 150th Annual Meeting, Philadelphia Workshop Chair

1994 American Psychiatric Association 150th Annual Meeting, Philadelphia Workshop Speaker

1994 American Psychiatric Association 150th Annual Meeting, Philadelphia Paper Session Co-
 chair

1995 Spring Meeting of the Association of Gay and Lesbian Psychiatrists, Miami Beach Symposium Chair

1996 American Psychiatric Association 152nd Annual Meeting, New York Workshop Speaker

1997 American Psychiatric Association Annual Meeting, San Diego Workshop Speaker

1997 Gay and Lesbian Medical Association Annual Invited Speaker Symposium

1998 American Psychiatric Association Annual Meeting, Toronto Workshop Chair

1998 American Psychiatric Association Annual Meeting, Toronto Workshop Chair

1998 American Psychiatric Association Annual Meeting, Toronto Media Session
 Chair

1998 American Psychiatric Association Annual Meeting, Media Session

	Toronto	Chair
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Symposium Chair
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Symposium Presenter
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Workshop Chair
2000	American Psychiatric Association Annual Meeting, Chicago	Workshop Chair
2000	National Youth Leadership Forum On Medicine, University of California, Berkeley	Invited Speaker
2001	American Psychiatric Association Annual Meeting, New Orleans	Workshop Chair
2001	American Psychiatric Association Annual Meeting, New Orleans	Media Program Chair
2001	Association of Gay and Lesbian Psychiatrists	Chair Symposium, New Orleans
2001	Harry Benjamin International Gender Dysphoria Association Biennial Meeting, Galveston, Texas	Invited Speaker
2002	American Psychiatric Association Annual Meeting, Philadelphia	Media Program Chair
2002	American Psychiatric Association Annual Meeting, Philadelphia	Workshop Chair
2002	American Psychiatric Association Annual Meeting, Philadelphia	Workshop Chair
2003	Association of Gay and Lesbian Psychiatrists CME	Chair Conference
2003	American Psychiatric Association Annual Meeting, San Francisco	Symposium Chair
2003	American Psychiatric Association Annual Meeting, San Francisco	Symposium Co-Chair
2003	American Psychiatric Association Annual Meeting, San Francisco	Workshop Chair
2003	American Public Health Association Annual Meeting, San Francisco	Invited Speaker
2004	Mission Mental Health Clinic Clinical Conference	Invited Speaker
2004	Association of Gay and Lesbian Psychiatrists Conference, New York	Co-Chair
2004	Mental Health Care Provider Education Program: Los	Invited Speaker

	Angeles. Sponsored by the American Psychiatric Association Office of HIV Psychiatry	
2005	American Psychiatric Association Annual Meeting, Atlanta	Workshop Speaker
2005	Association of Gay and Lesbian Psychiatrists Saturday Symposium	Invited Speaker
2008	Society for the Study of Psychiatry and Culture, San Francisco	Invited Speaker
2009	American Psychiatric Association Annual Meeting, San Francisco	Symposium Speaker
2011	National Transgender Health Summit, San Francisco	Invited Speaker
2011	National Transgender Health Summit, San Francisco	Invited Speaker
2011	American Psychiatric Association Annual Meeting, Honolulu, HI	Symposium Chair
2011	American Psychiatric Association Annual Meeting, Honolulu, HI	Symposium Speaker
2011	World Professional Association for Transgender Health Conference, Atlanta, GA	Invited Speaker Biennial
2011	World Professional Association for Transgender Health Conference, Atlanta, GA	Invited Speaker Biennial

		Invited Speaker
2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA	
2011	Institute on Psychiatric Services, San Francisco	Invited Speaker
2012	Gay and Lesbian Medical Association Annual Meeting	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	American Psychiatric Association Annual Meeting, San Francisco	Invited Speaker
2013	Gay and Lesbian Medical Association, Denver, CO	Invited Speaker
2014	American Psychiatric Association Annual Meeting, New York	Invited Speaker
2014	Institute on Psychiatric Services, San Francisco	Moderator
2014	Institute on Psychiatric Services, San Francisco	Invited Speaker
2014	Institute on Psychiatric Services, San Francisco	Invited Speaker
2015	National Transgender Health Summit, Oakland, CA	Invited Speaker
2015	National Transgender Health Summit, Oakland, CA	Invited Speaker
2015	American Psychiatric Association Annual Meeting, Toronto	Workshop Speaker
2015	American Psychiatric Association Annual Meeting, Toronto	Course Faculty
2016	American Psychiatric Association Annual Meeting	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Atlanta	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Springfield, MO	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Fort Lauderdale, FL	Course Faculty
2017	World Professional Association for Transgender Health, GEI, Los Angeles	Course Faculty
	World Professional Association for Transgender Health	

Surgeon's Training, Irvine, CA Course Faculty

2017	American Urological Association Annual Meeting, San Francisco CA Invited Speaker
2018	World Professional Association for Transgender Health GEI, Portland OR, Course Faculty
2018	World Professional Association for Transgender Health GEI, Palm Springs, Course Faculty
2019	American Society for Adolescent Psychiatry Annual Meeting, San Francisco, Speaker
2019	American Psychiatric Association Annual Meeting, San Francisco, Session Chair
2020	Psychiatric Congress, Invited Speaker
2022	World Professional Association for Transgender Health, Montreal, invited speaker
2023	National Transgender Health Summit, San Francisco, invited speaker
2023	American Psychiatric Association Annual Meeting, San Francisco, invited speaker

INVITED PRESENTATIONS - REGIONAL AND OTHER INVITED PRESENTATIONS

1990	Advanced Group Therapy Seminar, UCLA Neuropsychiatric Institute	Invited Lecturer
1991	Joint Project of the Southern California AIDS Interfaith Council and UCLA School of Medicine	Symposium Speaker
1991	Joint Project of the Southern California AIDS Interfaith Council and UCLA School of Medicine	Workshop Panelist
1992	Advanced Group Therapy Seminar, UCLA Neuropsychiatric Institute	Invited Lecturer
1993	UCSF School of Nursing	Invited Lecturer
1995	UCSF/SFGH Department of Medicine Clinical Care Conference	Invited Speaker
1996	UCSF School of Nursing	Invited Speaker
1996	Psychopharmacology for the Primary Care AIDS/Clinician, series of four lectures, UCSF Department of Medicine	Invited Lecturer

		Invited Speaker
1996	UCSF AIDS Health Project Psychotherapy Internship Training Program	
1996	UCSF/SFGH Department of Medicine AIDS Quarterly Update	Invited Speaker
1996	San Francisco General Hospital, Division of Addiction Medicine	Invited Speaker
1996	UCSF Langley Porter Psychiatric Hospital and Clinics Rounds	Invited Speaker Grand
1997	UCSF School of Nursing	Invited Speaker
1997	UCSF Department of Medicine AIDS Program	Invited Speaker
1997	Northern California Psychiatric Society Annual Meeting, Monterey	Workshop Speaker
1997	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1997	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1997	Northern California Psychiatric Society LGBT Committee	Chair Fall Symposium
1997	Progress Foundation, San Francisco	Invited Speaker
1998	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1999	Northern California Psychiatric Society Annual Meeting, Santa Rosa	Invited Speaker
1999	Northern California Psychiatric Society Annual Meeting, Santa Rosa	Invited Speaker
1999	University of California, Davis, Department of Psychiatry Grand Rounds	Invited Speaker Grand
1999	California Pacific Medical Center Department of Psychiatry Grand Rounds	Invited Speaker Psychiatry
1999	San Francisco General Hospital Department of Psychiatry Departmental Case Conference	Discussant
2000	Langley Porter Psychiatric Hospital and Clinics Consultation Liaison Seminar	Invited Speaker
2000	San Francisco General Hospital, Psychopharmacology Seminar	Invited Speaker
2000	UCSF Transgender Health Conference, Laurel Heights Conference Center	Invited Speaker

2000	Psychiatry Course for UCSF Second Year Medical Students	Invited Lecturer
2000	Community Consortium Treatment Update Symposium, California Pacific Medical Center, Davies Campus	Invited Speaker
2000	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
2001	Psychiatry Course for UCSF Second Year Medical Students	Invited Lecturer
2003	Tom Waddell Health Center Inservice	Invited Speaker
2003	San Francisco Veterans Affairs Outpatient Clinic	Invited Speaker
2004	San Francisco General Hospital Psychiatric Emergency Service Clinical Conference	Invited Speaker
2004	South of Market Mental Health Clinic, San Francisco	Invited Speaker
2005	Northern Psychiatric Society Annual Meeting	Invited Speaker
2005	Equality and Parity: A Statewide Action for Transgender Prevention and Care, San Francisco	Invited Speaker HIV
2005	San Francisco General Hospital Department of Psychiatry Grand Rounds.	Invited Speaker
2006	SFGH/UCSF Department of Psychiatry Grand Rounds	Invited Speaker
2007	UCSF Department of Medicine, HIV/AIDS Grand Rounds, Positive Health Program	Invited Speaker
2007	California Pacific Medical Center LGBT Health, San Francisco LGBT Community Center	Invited Speaker Symposium,
2007	UCSF CME Conference, Medical Management of HIV/AIDS, Fairmont Hotel, San Francisco	Invited Speaker
2008	UCSF Department of Medicine, Positive Health Program, HIV/AIDS Grand Rounds	Invited Speaker
2008	San Francisco General Hospital Psychiatry Grand Rounds	Invited Speaker
2008	UCSF CME Conference, Medical Management of HIV/AIDS, Fairmont Hotel, San Francisco	Invited Speaker
2010	Northern California Psychiatric Society Annual Meeting, Monterey, CA	Invited Speaker
2011	Transgender Mental Health Care Across the Life Span, Stanford University	Invited Speaker
2011	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
2012	UCSF AIDS Health Project Veterans Affairs Medical Center.	Invited Speaker 2012 San Francisco

		Invited Speaker
2013	Association of Family and Conciliation Courts Conference, Los Angeles, CA	Invited Speaker
2014	UCSF Transgender Health elective	Invited Speaker
2014	UCSF Department of Psychiatry Grand Rounds	Invited Speaker
2014	California Pacific Medical Center Department of Psychiatry Grand Rounds	Invited Speaker
2014	UCLA Semel Institute Department of Psychiatry Grand Rounds	Invited Speaker
2015	UCSF Transgender Health elective	Invited Speaker
2015	Fenway Health Center Boston, MA (webinar)	Invited Speaker
2015	Transgender Health Symposium, Palm Springs	Invited Speaker
2015	Transgender Health Symposium, Palm Springs	Co-Chair
2015	Santa Clara Valley Medical Center Grand Rounds	Invited Speaker
2016	UCSF School of Medicine Transgender Health elective	Invited Speaker
2016	Langley Porter Psychiatric Institute APC Case Conference	Invited Speaker (2 session series)
2016	Zuckerberg San Francisco General Department of Psychiatry Grand Rounds	Invited Speaker
2016	UCSF Mini-Medical School Lectures to the Public	Invited Speaker
2021	Los Angeles County Department of Mental Health,	Invited Speaker

CONTINUING EDUCATION AND PROFESSIONAL DEVELOPMENT ACTIVITIES

2005	Northern California Psychiatric Society
2005	Northern California Psychiatric Society Annual Meeting, Napa
2005	Association of Gay and Lesbian Psychiatrist Annual Conference
2006	Annual Meeting, American Psychiatric Association, Atlanta
2006	Annual Meeting, American Psychiatric Association, Toronto
2006	Institute on Psychiatric Services, New York
2007	Association of Gay and Lesbian Psychiatrists Annual Conference
2007	American Psychiatric Association Annual Meeting, San Diego
2007	The Medical Management of HIV/AIDS, a UCSF CME Conference
2008	Society for the Study of Psychiatry and Culture, San Francisco

2009 American Psychiatric Association, San Francisco
2009 World Professional Association for Transgender Health, Oslo, Norway
2010 Annual Meeting of the Northern California Psychiatric Society, Monterey, CA
2011 Transgender Mental Health Care Across the Life Span, Stanford University
2011 National Transgender Health Summit, San Francisco
2011 American Psychiatric Association Annual Meeting, Honolulu, HI
2011 World Professional Association for Transgender Health Biennial Conference, Atlanta, GA
2011 Institute on Psychiatric Services, San Francisco
2012 Gay and Lesbian Medical Association Annual Meeting, San Francisco
2013 National Transgender Health Summit, Oakland, CA
2013 American Psychiatric Association Annual Meeting, San Francisco
2013 Gay and Lesbian Medical Association, Denver, CO
2014 American Psychiatric Association Annual Meeting, New York
2014 Institute on Psychiatric Services, San Francisco
2015 European Professional Association for Transgender Health, Ghent, Belgium
2015 National Transgender Health Summit, Oakland
2015 American Psychiatric Association Annual Meeting, Toronto
2016 American Psychiatric Association Annual Meeting, Atlanta
2016 World Professional Association for Transgender Health, Amsterdam

GOVERNMENT AND OTHER PROFESSIONAL SERVICE

1998 - 2002 City and County of San Francisco Human Rights Member Commission LGBT
Advisory Committee

I am the chair of the American Psychiatric Association Workgroup on Gender Dysphoria, which developed a CME course for the 2015 and 2016 APA Annual Meetings, and is now embarking on a larger educational mission to train American psychiatrists to better care for transgender patients. I have been leading education efforts in transgender health at APA meetings since 1998. On the APA Workgroup on Gender Dysphoria, I am a co-author of a paper of transgender issues that has been approved by the American Psychiatric Association as a resource document and is in press for the American Journal of Psychiatry. I am also the sole author of the chapter on transgender care in the American Psychiatric Press's Clinical Manual of Cultural Psychiatry, Second Edition.

I have been active internationally in transgender health through my work as a member of the Board of Directors of the World Professional Association for Transgender Health. I am an author of the WPATH Standards of Care, Version 7, and am Chapter Lead for the Mental Health Chapter of SOC 8.

I chaired the WPATH Public Policy Committee and was a member of the Global Education Initiative, which developed a specialty certification program in transgender health. I helped plan the 2016 WPATH Amsterdam conference, and was on the scientific committee for the last four biennial international conferences. I was on the founding committee of USPATH, the national affiliate of WPATH, and I chaired the inaugural USPATH conference, in Los Angeles in 2017. As a member of the steering committee of the WPATH Global Educational Initiative, I helped train over 2000 health providers in transgender health, and helped develop a board certification program and examination in transgender health.

UNIVERSITY SERVICE UC SYSTEM AND MULTI-CAMPUS SERVICE

1991 – 2003	HIV/AIDS Task Force	Member
1992 - 1993	HIV Research Group	Member
1992 - 1997	Space Committee	Member
1992 - 2003	Gay, Lesbian and Bisexual Issues Task Force	Member
1994 - 1997	SFGH Residency Training Committee	Member
1996 - 1997	Domestic Partners Benefits Subcommittee.	Chair
1996 - 2000	Chancellor's Advisory Committee on Gay, Lesbian, and Transgender Issues.	Member Bisexual
1996 - 2003	HIV/AIDS Task Force	Co-Chair
1996 - 2003	Cultural Competence and Diversity Program	Member
2009 - present	Medical Advisory Board, UCSF Center of Excellence for Health	Member Transgender
2010 - 2013	Steering Committee, Child Adolescent Gender Center	Member
2011 – 2017	Mental Health Track, National Transgender Health Summit	Chair

DEPARTMENTAL SERVICE

- 1991 - 2003 San Francisco General Hospital, Department of Psychiatry, Member HIV/AIDS Task Force
- 1992 - 1993 San Francisco General Hospital, Department of Psychiatry, Member HIV Research Group
- 1992 - 1997 San Francisco General Hospital, Department of Psychiatry, Member Space Committee
- 1992 - 2003 San Francisco General Hospital, Department of Psychiatry, Member GLBT Issues Task Force
- 1994 - 1997 San Francisco General Hospital, Department of Psychiatry, Member Residency Training Committee
- 1996 - 2003 San Francisco General Hospital, Department of Psychiatry, Member Cultural Competence and Diversity Program
- 1996 - 2003 San Francisco General Hospital, Department of Psychiatry, Co-Chair HIV/AIDS Task Force
- 2012 - 2020 San Francisco Department of Public Health Gender Member Competence Trainings Committee
- 2013 - 2020 San Francisco Department of Public Health Transgender Member Health Implementation Task Force
- 2014 - 2020 San Francisco General Hospital, Department of Psychiatry, Member Transgender Surgery Planning Workgroup

PEER REVIEWED PUBLICATIONS

1. Berliner JA, Frank HJL, **Karasic D**, Capdeville M. Lipoprotein-induced insulin resistance in aortic endothelium. *Diabetes*. 1984; 33:1039-44.
2. Bradberry CW, **Karasic DH**, Deutch AY, Roth RH. Regionally-specific alterations in mesotelencephalic dopamine synthesis in diabetic rats: association with precursor tyrosine. *Journal of Neural Transmission. General Section*, 1989; 78:221-9.
3. Targ EF, **Karasic DH**, Bystritsky A, Diefenbach PN, Anderson DA, Fawzy FI. Structured group therapy and fluoxetine to treat depression in HIV-positive persons. *Psychosomatics*. 1994; 35:132-7.
4. Karasic DH. Homophobia and self-destructive behaviors. *The Northern California Psychiatric Physician*. 1996; 37 Nov.-Dec. Reprinted by the Washington State Psychiatric Society and the Southern California Psychiatric Society newsletters.
5. Karasic D. Anxiety and anxiety disorders. *Focus*. 1996 Nov; 11(12):5-6. PMID: 12206111
6. Polansky JS, **Karasic DH**, Speier PL, Hastik KL, Haller E. Homophobia: Therapeutic and training considerations for psychiatry. *Journal of the Gay and Lesbian Medical Association*. 1997 1(1) 41-47.

7. Karasic DH. Progress in health care for transgendered people. Editorial. Journal of the Gay and Lesbian Medical Association, 4(4) 2000 157-8.
8. Perry S, **Karasic D**. Depression, adherence to HAART, and survival. Focus: A Guide to AIDS Research and Counseling. 2002 17(9) 5-6.
9. Fraser L, **Karasic DH**, Meyer WJ, Wylie, K. Recommendations for Revision of the DSM Diagnosis of Gender Identity Disorder in Adults. International Journal of Transgenderism. Volume 12, Issue 2. 2010, Pages 80-85.
10. Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W., Monstrey, S., **Karasic D** and 22 others. (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version. International Journal of Transgenderism, 13:165-232, 2011
11. Tsai AC, **Karasic DH**, et al. Directly Observed Antidepressant Medication Treatment and HIV Outcomes Among Homeless and Marginally Housed HIV-Positive Adults: A Randomized Controlled Trial. American Journal of Public Health. February 2013, Vol. 103, No. 2, pp. 308-315.
12. Tsai AC, Mimmiaga MJ, Dilley JW, Hammer GP, **Karasic DH**, Charlebois ED, Sorenson JL, Safren SA, Bangsberg DR. Does Effective Depression Treatment Alone Reduce Secondary HIV Transmission Risk? Equivocal Findings from a Randomized Controlled Trial. AIDS and Behavior, October 2013, Volume 17, Issue 8, pp 2765-2772.
13. **Karasic DH**. Protecting Transgender Rights Promotes Transgender Health. LGBT Health. 2016 Aug; 3(4):245-7. PMID: 27458863
14. Winter S, Diamond M, Green J, **Karasic D**, Reed T, Whittle S, Wylie K. Transgender people: health at the margins of society. Lancet. 2016 Jul 23;388(10042):390-400. doi: 10.1016/S0140-6736(16)00683-8. Review./> PMID: 27323925
15. Grelotti DJ, Hammer GP, Dilley JW, **Karasic DH**, Sorensen JL, Bangsberg DR, Tsai AC. Does substance use compromise depression treatment in persons with HIV? Findings from a randomized controlled trial. AIDS Care. 2016 Sep 2:1-7. [Epub ahead of print]/> PMID: 27590273
16. Strang JF, Meagher H, Kenworthy L, de Vries AL, Menvielle E, Leibowitz S, Janssen A, Cohen-Kettenis P, Shumer DE, Edwards-Leeper L, Pleak RR, Spack N, **Karasic DH**, Schreier H, Balleur A, Tishelman A, Ehrensaft D, Rodnan L, Kushner ES, Mandel F, Caretto A, Lewis HC, Anthony LG. Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents. J Clin Child Adolesc Psychol. 2016 Oct 24:1-11. [Epub ahead of print]/> PMID: 27775428
17. Milrod C, **Karasic DH**. Age Is Just a Number: WPATH-Affiliated Surgeons' Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States. J Sex Med 2017;14:624–634.
18. William Byne, Dan H. Karasic, Eli Coleman, A. Evan Eyler, Jeremy D. Kidd, Heino F.L. Meyer-Bahlburg, Richard R. Pleak, and Jack Pula. Gender Dysphoria in Adults:

An Overview and Primer for Psychiatrists. *Transgender Health*. Dec 2018;57-A3. <http://doi.org/10.1089/trgh.2017.0053>

19. Identity recognition statement of the world professional association for transgender health (WPATH). *International Journal of Transgenderism*. 2018 Jul 3; 19(3):1-2. Knudson KG, Green GJ, Tangpricha TV, Ettner ER, Bouman BW, Adrian AT, Allen AL, De Cuypere DG, Fraser FL, Hansen HT, **Karasic KD**, Kreukels KB, Rachlin RK, Schechter SL, Winter WS, Committee and Board of Direct
20. **Karasic, DH** & Fraser, L. Multidisciplinary Care and the Standards of Care for Transgender and Gender Non-conforming Individuals. Schechter, L & Safa, B. (Eds.) *Gender Confirmation Surgery, Clinics in Plastic Surgery Special Issue, Vol 45, Issue 3*, pp 295-299. 2018 Elsevier, Philadelphia. <https://doi.org/10.1016/j.cps.2018.03.016>
21. Milrod C, Monto M, **Karasic DH**. Recommending or Rejecting "the Dimple": WPATH-affiliated Medical Professionals' Experiences and Attitudes Toward Gender-Confirming Vulvoplasty in Transgender Women. *J Sex Med*. 2019 Apr;16(4):586-595. doi: 10.1016/j.jsxm.2019.01.316. Epub 2019 Mar 2.
22. ICD-11 and gender incongruence of childhood: a rethink is needed. *Lancet Child Adolesc Health*. 2019 10; 3(10):671-673. Winter S, [Ehrensaft D](#), Telfer M, T'Sjoen G, Koh J, Pickstone-Taylor S, Kruger A, Griffin L, Foigel M, De Cuypere G, **Karasic D**. PMID: 31439494.
23. Gender Dysphoria in Adults: An Overview and Primer for Psychiatrists. *Focus (Am Psychiatr Publ)*. 2020 Jul; 18(3):336-350. Byne W, **Karasic DH**, Coleman E, Eyler AE, Kidd JD, Meyer-Bahlburg HFL, Pleak RR, Pula J. PMID: 33343244; PMCID: [PMC7587914](#).
24. WPATH Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, **D. H. Karasic**, G. A. Knudson, S. F. Leibowitz, H. F. L. Meyer-Bahlburg, S. J. Monstrey, J. Motmans, L. Nahata, T. O. Nieder, S. L. Reisner, C. Richards, L. S. Schechter, V. Tangpricha, A. C. Tishelman, M. A. A. Van Trotsenburg, S. Winter, K. Ducheny, N. J. Adams, T. M. Adrián, L. R. Allen, D. Azul, H. Bagga, K. Başar, D. S. Bathory, J. J. Belinky, D. R. Berg, J. U. Berli, R. O. Bluebond-Langner, M.- B. Bouman, M. L. Bowers, P. J. Brassard, J. Byrne, L. Capitán, C. J. Cargill, J. M. Carswell, S. C. Chang, G. Chelvakumar, T. Corneil, K. B. Dalke, G. De Cuypere, E. de Vries, M. Den Heijer, A. H. Devor, C. Dhejne, A. D'Marco, E. K. Edmiston, L. Edwards-Leeper, R. Ehrbar, D. Ehrensaft, J. Einfeld, E. Elaut, L. Erickson-Schroth, J. L. Feldman, A. D. Fisher, M. M. Garcia, L. Gijs, S. E. Green, B. P. Hall, T. L. D. Hardy, M. S. Irwig, L. A. Jacobs, A. C. Janssen, K. Johnson, D. T. Klink, B. P. C. Kreukels, L. E. Kuper, E. J. Kvach, M. A. Malouf, R. Massey, T. Mazur, C. McLachlan, S. D. Morrison, S. W. Mosser, P. M. Neira, U. Nygren, J. M. Oates, J. Obedin-Maliver, G. Pagkalos, J. Patton, N. Phanuphak, K. Rachlin, T. Reed, G. N. Rider, J. Ristori, S. Robbins-Cherry, S. A. Roberts, K. A. Rodriguez-Wallberg, S. M. Rosenthal, K. Sabir, J. D. Safer, A. I. Scheim, L. J. Seal, T. J. Sehoole, K. Spencer, C. St. Amand, T. D. Steensma, J. F. Strang, G. B. Taylor, K. Tilleman, G. G. T'Sjoen, L. N. Vala, N. M. Van Mello,

J. F. Veale, J. A. Vencill, B. Vincent, L. M. Wesp, M. A. West & J. Arcelus (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, International Journal of Transgender Health, 23:sup1, S1-S259, DOI: 10.1080/26895269.2022.2100644

BOOKS AND CHAPTERS

1. **Karasic DH**, Dilley JW. Anxiety and depression: Mood and HIV disease. In: The UCSF AIDS Health Project Guide to Counseling: Perspectives on Psychotherapy, Prevention, and Therapeutic Practice. Dilley JW and Marks R, eds. Jossey-Bass. San Francisco, 1998, pp.227-248.
2. **Karasic DH**, Dilley JW. Human immunodeficiency-associated psychiatric disorders. In: The AIDS Knowledge Base, Third Edition. Cohen PT, Sande MA, Volberding PA, eds. Lippincott-Williams &Wilkins, Philadelphia, 1999, pp. 577-584.
3. **Karasic DH** and Drescher J. eds. Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation. 2005. Haworth Press, Binghamton, NY. (Book Co-Editor)
4. **Karasic DH**. Transgender and Gender Nonconforming Patients. In: Clinical Manual of Cultural Psychiatry, Second Edition. Lim RF ed. pp 397-410. American Psychiatric Publishing, Arlington VA. 2015.
5. **Karasic DH**. Mental Health Care of the Transgender Patient. In: Comprehensive Care of the Transgender Patient, Ferrando CA ed. pp. 8-11. Elsevier, 2019.
6. **Karasic DH**. The Mental Health Assessment for Surgery. In: Gender Confirmation Surgery – Principles and Techniques for an Emerging Field. Schechter L ed. Springer Nature, in press 2019.

OTHER PUBLICATIONS

1. **Karasic DH**, Dilley JW. HIV-associated psychiatric disorders: Treatment issues. In: Cohen P, Sande MA, Volberding P, eds., The AIDS Knowledge Base. Waltham, MA: The Medical Publishing Group/ Massachusetts Medical Society. 1994. pp. 5.31-1-5.
2. **Karasic DH**, Dilley JW. HIV-associated psychiatric disorders: Clinical syndromes and diagnosis. In: Cohen P, Sande MA, Volberding P, eds., The AIDS Knowledge Base, Second Edition. Waltham, MA: The Medical Publishing Group/Massachusetts Medical Society. 1994 pp. 5.30-1-5.
3. **Karasic DH**. A primer on transgender care. In: Gender and sexuality. The Carlat Report Psychiatry. April 2012. Vol 10, Issue 4.
4. **Karasic D and Ehrensaft D**. We must put an end to gender conversion therapy for kids. Wired. 7/6/15.

EXPERT WITNESS AND CONSULTATION ON TRANSGENDER CARE AND RIGHTS

2008 Consultant, California Department of State Hospitals

2012 Dugan v. Lake, Logan UT

2012 XY v. Ontario <http://www.canlii.org/en/on/onhrt/doc/2012/2012hrto726/2012hrto726.html>

2014 Cabading v California Baptist University

2014 CF v. Alberta

<http://www.canlii.org/en/ab/abqb/doc/2014/2014abqb237/2014abqb237.html>

2017 United Nations Development Programme consultant, transgender health care and legal rights in the Republic of Vietnam; Hanoi.

2017- Forsberg v Saskatchewan; Saskatchewan Human Rights v Saskatchewan

2018 <https://canliiconnects.org/en/summaries/54130>

<https://canliiconnects.org/en/cases/2018skqb159>

2018 United Nations Development Programme consultant, transgender legal rights in Southeast Asia; Bangkok.

2018 Consultant, California Department of State Hospitals

2019, 2021 Consultant/Expert, Disability Rights Washington

2019, 2021 Consultant/Expert, ACLU Washington

2021 Consultant, California Department of Corrections and Rehabilitation

2021 Expert, Kadel v. Folwell, 1:19-cv-00272 (M.D.N.C.).

2021 Expert, Drew Glass v. City of Forest Park - Case No. 1:20-cv-914 (Southern District Ohio)

2021-2022 Expert, Brandt et al v. Rutledge et al. 4:21-cv-00450 (E.D. Ark.)

2021-2022 Expert, Fain v. Crouch, 3:20-cv-00740 (S.D.W. Va.)

2022 Expert, C.P. v. Blue Cross Blue Shield of Illinois, No. 3:20-cv-06145-RJB (W.D. Wash.)

EXHIBIT B

EXHIBIT B – DAN KARASIC BIBLIOGRAPHY

Achille, C., Taggart, T., Eaton, N. R., Osipoff, J., Tafuri, K., Lane, A., & Wilson, T. A. (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(8), available at <https://doi.org/10.1186/s13633-020-00078-2>.

American Psychological Association. (2021). APA Resolution on Gender Identity Change Efforts. Available at <https://www.apa.org/about/policy/resolution-gender-identity-changeefforts.pdf>.

Brik, T., Vrouenraets, L. J. J. J., de Vries, M. C., & Hannema, S. E. (2020). Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria. *Archives of Sexual Behavior*, 49(7), 2611–2618. <https://doi.org/10.1007/s10508-020-01660-8>.

Bakker A., van Kesteren P. J. M., Gooren L. J. G., et al. (1993). The prevalence of transsexualism in the Netherlands. *Acta Psychiatry Scand*, 87(4), 237-238.

Bustos, V. P., Bustos, S. S., Mascaro, A., Del Corral, G., Forte, A. J., Ciudad, P., Kim, E. A., Langstein, H. N., & Manrique, O. J. (2021). Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence. *Plastic and Reconstructive Surgery-Global open*, 9(3), e3477, available at <https://doi.org/10.1097/GOX.0000000000003477>.

Chen, D., Berona, J., Chan, Y. M., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., Rosenthal, S. M., Tishelman, A. C., & Olson-Kennedy, J. (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *The New England Journal of Medicine*, 388(3), 240–250. <https://doi.org/10.1056/NEJMoa2206297>.

Chong, M. C., Sharp, M. K., Smith, S. M., O'Neill, M., Ryan, M., Lynch, R., Mahtani, K. R., & Clyne, B. (2023). Strong recommendations from low certainty evidence: a cross-sectional analysis of a suite of national guidelines. *BMC Medical Research Methodology*, 23(1), 68. <https://doi.org/10.1186/s12874-023-01895-8>.

Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., Nieder, T. O., ... Arcelus, J. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health*, 23(Suppl 1), S1– S259.

Coleman, E., Bockting, W., Botzer, M., et al. (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (7th Version). The World Professional Association for Transgender Health. Available at https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?t=1613669341.

Conron, K. J., Scott, G., Stowell, G. S., & Landers, S. J. (2012). Transgender health in Massachusetts: results from a household probability sample of adults. *American Journal of Public Health*, 102(1), 118-122, available at <https://doi.org/10.2105/AJPH.2011.300315>.

Conway, A., Conway, Z., Soalheira, K., & Sutherland, J. (2017). High quality of evidence is uncommon in Cochrane systematic reviews in Anaesthesia, Critical Care and Emergency Medicine. *European Journal of Anaesthesiology*, 34(12), 808–813, available at <https://doi.org/10.1097/EJA.0000000000000691>.

Costa, R., Dunsford, M., Skagerberg, E., Holt, V., Carmichael, P., & Colizzi, M. (2015). Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. *The Journal of Sexual Medicine*, 12(11), 2206–2214. <https://doi.org/10.1111/jsm.13034>

Crissman, H. P., Berger, M. B., Graham, L. F., & Dalton, V. K. (2017). Transgender Demographics: A Household Probability Sample of US Adults, 2014. *American Journal of Public Health*, 107(2), 213–215, available at <https://doi.org/10.2105/AJPH.2016.303571>.

de Vries, A. L., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *The Journal of Sexual Medicine*, 8(8), 2276–2283, available at <https://doi.org/10.1111/j.1743-6109.2010.01943>.

de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment. *Pediatrics*, 134(4), 696–704, available at <https://doi.org/10.1542/peds.2013-2958>.

Dhejne, C., Öberg, K., Arver, S., & Landén, M. (2014). An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: prevalence, incidence, and regrets. *Archives of Sexual Behavior*, 43(8), 1535–1545, available at <https://doi.org/10.1007/s10508-014-0300-8>.

Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A., Langstrom, N., Landen, M., (2011). Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. *PLoS ONE* 6(2): e16885. <https://doi.org/10.1371/journal.pone.0016885>.

Dhejne, C. H. (2017). Science AMA Series: I’m Cecilia Dhejne a fellow of the European Committee of Sexual Medicine, from the Karolinska University Hospital in Sweden. I’m here to talk about transgender health, suicide rates, and my often misinterpreted study. Ask me anything! *Winnower* 10:e150124.46274

Ehrensaft, D. (2017). Gender nonconforming youth: current perspectives. *Adolescent Health, Medicine and Therapeutics*, 8, 57–67, available at <https://doi.org/10.2147/AHMT.S110859>.

Fleming, P. S., Koletsi, D., Ioannidis, J. P. A., & Pandis, N. (2016). High quality of the evidence for medical and other health-related interventions was uncommon in Cochrane systematic reviews. *Journal of Clinical Epidemiology* 78, 34–42, available at <https://doi.org/10.1016/j.jclinepi.2016.03.012>.

Flores, A. R., Herman, J. L., Gates, G. J., & Brown, T. N. T. (2016). How Many Adults Identify as Transgender in the United States? The Williams Institute, available at <https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/>.

Green, A. E., DeChants, J. P., Price, M. N., & Davis, C. K. (2022). Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. *The Journal of Adolescent Health, 70*(4), 643–649. <https://doi.org/10.1016/j.jadohealth.2021.10.036>.

Green, R. (1987). *The “Sissy Boy Syndrome” and the Development of Homosexuality*. New Haven, CT: Yale University Press.

Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S., Meyer, W. J., Murad, M. H., ... T’Sjoen, G. G. (2017). Endocrine treatment of genderdysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *The Journal of Clinical Endocrinology & Metabolism, 102*(11), 3869-3903, available at <https://doi.org/10.1210/jc.2017-01658>.

Herman, J. L., Flores, A. R., Brown, T. N. T., Wilson, B. D. M., & Conron, K. J. (2017). Age of Individuals Who Identify as Transgender in the United States. The Williams Institute, available at <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Age-Trans-Individuals-Jan-2017.pdf>.

Howick, J., Koletsi, D., Pandis, N., Fleming, P. S., Loef, M., Walach, H., Schmidt, S., & Ioannidis, J. P. A. (2020). The quality of evidence for medical interventions does not improve or worsen: a metaepidemiological study of Cochrane reviews. *Journal of Clinical Epidemiology, 126*, 154–159, available at <https://doi.org/10.1016/j.jclinepi.2020.08.005>.

Howick, J., Koletsi, D., Ioannidis, J. P. A., Madigan, C., Pandis, N., Loef, M., Walach, H., Sauer, S., Kleijnen, J., Sehra, J., Johnson, T., & Schmidt, S. (2022). Most healthcare interventions tested in Cochrane Reviews are not effective according to high quality evidence: a systematic review and meta-analysis. *Journal of Clinical Epidemiology, 148*, 160–169., available at <https://doi.org/10.1016/j.jclinepi.2022.04.017>.

Johns, M. M., Lowry, R., Andrzejewski, J., Barrios, L. C., Demissie, Z., McManus, T., Rasberry, C. N., Robin, L., & Underwood, J. M. (2019). Transgender identity and experiences of violence victimization, substance use, suicide risk, and sexual risk behaviors among high school students - 19 states and large urban school districts, 2017. *Morbidity and Mortality Weekly Report, 68*(3), 67-71, available at <https://doi.org/10.15585/mmwr.mm6803a3>.

Kaltiala, R., Heino, E., Työlajärvi, M., & Suomalainen, L. (2020). Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nordic Journal of Psychiatry, 74*(3), 213–219. <https://doi.org/10.1080/08039488.2019.1691260>.

Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy. *Pediatrics, 145*(4), e20193006, available at <https://doi.org/10.1542/peds.2019-300>.

van der Loos, M. A. T. C., Hannema, S. E., Klink, D. T., den Heijer, M., & Wiepjes, C. M. (2022). Continuation of gender-affirming hormones in transgender people starting puberty suppression in adolescence: a cohort study in the Netherlands. *The Lancet. Child & Adolescent Health, 6*(12), 869–875. [https://doi.org/10.1016/S2352-4642\(22\)00254-1](https://doi.org/10.1016/S2352-4642(22)00254-1).

- van der Miesen, A. I. R., Steensma, T. D., de Vries, A. L. C., Bos, H., & Popma, A. (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), 699–704, available at <https://doi.org/10.1016/j.jadohealth.2019.12.018>.
- Movsisyan, A., Melendez-Torres, G. J., & Montgomery, P. (2016). Outcomes in systematic reviews of complex interventions never reached "high" GRADE ratings when compared with those of simple interventions. *Journal of Clinical Epidemiology, 78*, 22–33, available at <https://doi.org/10.1016/j.jclinepi.2016.03.014>.
- Olson, K. R., Durwood, L., Horton, R., Gallagher, N. M., & Devor, A. (2022). Gender Identity 5 Years After Social Transition. *Pediatrics, 150*(2), e2021056082. <https://doi.org/10.1542/peds.2021-056082>.
- Rae, J. R., Gülgöz, S., Durwood, L., DeMeules, M., Lowe, R., Lindquist, G., & Olson, K. R. (2019). Predicting early-childhood gender transitions. *Psychological Science, 30*(5), 669–681. <https://doi.org/10.1177/0956797619830649>.
- Rider, G. N., McMorris, B. J., Gower, A. L., Coleman, E., & Eisenberg, M. E. (2018). Health and care utilization of transgender and gender nonconforming youth: A population-based study. *Pediatrics, 141*(3) e20171683, available at <https://doi.org/10.1542/peds.2017-1683>.
- Steensma T. D., Biemond R., de Boer F., & Cohen-Kettenis P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry, 16*(4), 499-516.
- Steensma, T. D., et al. (2013). Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study. *Journal of the American Academy of Child & Adolescent Psychiatry, 52*(6), 582-590.
- Tordoff, D. M., Wanta, J. W., Collin, A., Stepney, C., Inwards-Breland, D. J., & Ahrens, K. (2022). Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Network Open, 5*(2), e220978. <https://doi.org/10.1001/jamanetworkopen.2022.0978>.
- Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics, 145*(2), e20191725. <https://doi.org/10.1542/peds.2019-1725>
- Wiepjes, C. M., Nota, N. M., de Blok, C. J., Klaver, M., de Vries, A.L., Wensing-Kruger, S.A., ... & Gooren, L.J. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): trends in prevalence, treatment, and regrets. *The Journal of Sexual Medicine, 15*(4), 582-590, available at <https://doi.org/10.1016/j.jsxm.2018.01.016>.
- Zucker, K., et al. (2010). Puberty-Blocking Hormonal Therapy for Adolescents with Gender Identity Disorder: A Descriptive Clinical Study. *Journal of Gay & Lesbian Mental Health, 15*:1, 58-82, available at <http://dx.doi.org/10.1080/19359705.2011.530574>.

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.

**SUPPLEMENTAL DECLARATION
OF SUZANNE KINGERY, M.D.**

Civil No. 3:23-cv-230-DJH

SUPPLEMENTAL EXPERT DECLARATION OF SUZANNE KINGERY, M.D.

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

1. I previously submitted an Expert Declaration in the above-captioned litigation (Doc. 17-3).

2. I have reviewed four declarations submitted by Intervenor-Defendant Daniel Cameron in this case: declarations from James Cantor (Doc. 47-9), Michael Laidlaw (Doc. 47-10), Stephen Levine (Doc. 47-11), and Geeta Nangia (Doc. 47-12) (together “declarants”). The following responds to certain of declarants’ opinions.

I. The Multidisciplinary Treatment Team Model is Thoughtful and Deliberate.

3. Unlike the declarants, I have extensive personal experience providing care to transgender patients in Kentucky. The declarants’ submissions create a false impression that minor transgender patients are rushed into medical treatment for their gender dysphoria. That impression is inconsistent with my practice and the practice of the Pediatric and Adolescent Gender Education (“PAGE”) Program, where I am the director, which adheres to the approach recommended by the World Professional Association of Transgender Health (WPATH) Standards of Care and the Endocrine Society practice guidelines.

4. As I stated in my Expert Declaration, for each patient seen by the PAGE Program, we consult with a team of providers who have experience treating youth with gender dysphoria. Sometimes it can take a period of time before the team, along with the patient and their parents, determine that a minor is eligible to be treated with puberty blockers or cross sex hormone therapy. I have seen some patients for over a year before starting either course of treatment. The ultimate decision must be made on a case-by-case basis depending on the particular needs of each patient and in close communication with the patient and their parents.

5. Patients and their families are fully informed about the benefits and risks of available treatment options. I meet with each patient and their parents as many times as necessary to ensure that the patient and their parents have a full understanding of and can provide informed consent to the treatment.

6. Dr. Levine asserts that, in his view, transgender youth are put on a “conveyor belt” (Doc. 47-11, ¶ 49) path of care beginning with social transition. I do not agree with Dr. Levine’s overbroad and unsupported characterization, and unlike Dr. Levine I have relevant personal experience. The PAGE Program’s treatment model is not a one-size-fits-all approach, but is carefully crafted based on each patient’s individualized needs and circumstances.

7. Dr. Levine observes that in many cases, social transition leads to progression on to puberty blockers which in turn leads to the use of cross sex hormone therapy. (*Id.*, and ¶ 171). Dr. Levine implies that a harmful correlation exists between social transition and medical interventions with puberty blockers and hormone therapy. In my opinion, that implication reflects only Dr. Levine’s bias against the use medical interventions to treat gender dysphoria and is not founded in any scientific basis.

8. Many of the patients treated by the multidisciplinary team at the PAGE Program ultimately are prescribed either puberty blockers or cross sex hormone therapy or both. There is no evidence, anecdotal or otherwise, that suggests that social transition somehow causes the need for puberty blockers or hormone therapy. The reason that treatment with puberty blockers and cross sex hormone therapy often follows from a period of social transition is that gender dysphoria is real, consistent, persistent, and insistent, and puberty blockers and/or hormone therapy are the best, most well-supported treatment for the diagnosis of gender dysphoria for many adolescent transgender patients. It is my opinion that Dr. Levine's declaration reflects outlier opinions that are far outside the accepted mainstream of prevailing medical research and practice.

9. Dr. Nangia asserts in her declaration that every minor patient she has ever seen with gender dysphoria "grow[s] out of" it. (Doc. 47-12, ¶ 50).

10. I do not have personal knowledge of Dr. Nangia's patients, nor do I know how many patients with gender dysphoria she has seen. It would be unethical for me to speculate about the treatment or conditions of another doctor's patients. However, I am skeptical of Dr. Nangia's representation because it is inconsistent with my own clinical experience, as well as with the overwhelming medical and scientific literature and medical consensus. Pubertal children that present with gender dysphoria and that experience a persistent incongruence between their natal sex and their gender identity do not tend to just "grow out" of it.

11. Dr. Nangia also asserts in her declaration that gender dysphoria in children is better treated with psychotherapy alone until adulthood. (*Id.* at ¶ 163-70).

12. I am not at all opposed to the use of psychotherapy for the treatment of gender dysphoria in children as part of their multi-disciplinary course of care. However, it is not my experience that psychotherapy alone is an effective treatment or the best course of treatment for

gender dysphoria in every adolescent, nor is Dr. Nangia's opinion consistent with the expertise and recommendations of nearly every 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, which recognize the treatment of gender dysphoria with transition-related care. It is my opinion that Dr. Nangia's declaration reflects outlier opinions far outside the mainstream of prevailing medical research and practice.

13. Delaying medical interventions until adulthood, which is to say until when puberty is completed, however, may lead to long-term gender dysphoria. This can have harmful effects both psychologically and physically, and lead to the only option being more invasive and less effective treatments as an adult.

14. Dr. Laidlaw offers opinions about the appropriate course of treatment for each of the four children whose parents submitted a pseudonymous declaration in support of the Motion for Preliminary Injunction in this case. (Doc. 47-10, ¶¶ 234-62). Specifically, Dr. Laidlaw opines that all of the patients should stop treatments with puberty blockers or cross sex hormone therapy and should not be treated according to the accepted standards of care. (Doc. 47-10, ¶¶ 234, 246, 253(d), 262). Dr. Laidlaw has never met these patients or reviewed their medical records. It is improper and unethical for a doctor to opine about a patient's condition, diagnosis, or treatment plan without evaluating the patient. Dr. Laidlaw's opinion that none of the patients should be treated with medical interventions is of no value in any case, however, because it is also Dr. Laidlaw's opinion that the WPATH Standards of Care 8 should not be followed by any physician, mental health care provider, or other medical professionals. (Doc. 47-10, ¶ 185). As a result, Dr. Laidlaw's opinion about the proper treatment for a gender dysphoric patient is a foregone

conclusion that is not based on an evaluation of the actual circumstances of any particular patient, and Dr. Laidlaw's opinion should not be regarded as a medical opinion supported by evidence.

II. Dr. Cantor's Allegation of a Conflict of Interest.

15. In his declaration, Dr. Cantor alleges that because I treat transgender minor patients at my clinic, I have a conflict of interest in this case. (Doc. 47-9, ¶ 300). I disagree with Dr. Cantor's opinion, which is not based on any facts or evidence and is not within any field of expertise that Dr. Cantor appears to possess.

16. To allay any doubt about the impartiality of my opinions and my relation of facts to which I have personal knowledge, I will state the following. I am providing my expert opinion here at the request of Plaintiffs' counsel, and in order to provide first-hand information from my own personal knowledge about the status of health care for youth with gender dysphoria in Kentucky, as well as to demonstrate the impact that SB 150 would have on my ability to continue providing this care to my patients.

17. I am trained as a pediatric endocrinologist, and I provide care within that specialty to patients who are not transgender in addition to my transgender patients in the PAGE Program. I am committed to my work at the PAGE Program because I recognize the need for transgender youth to be able to access compassionate, well-informed, multidisciplinary health care for their gender dysphoria. My patients will suffer greatly if Section 4 of SB 150 takes effect. However, my ability to make a living as a doctor would not be substantially impacted.

18. As I previously stated (Doc. 17-3, ¶ 22), I am not being compensated for providing my opinions in this matter.

III. SIGNATURE

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

Executed this 14th day of June, 2023.

A handwritten signature in cursive script, appearing to read "Suzanne Kingery", written in black ink.

SUZANNE KINGERY, M.D.

**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.

Case No. 3:23-cv-00230-DJH

EXPERT REBUTTAL REPORT 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.

3. My background and qualifications, review of prior testimony, and compensation have been previously provided in my expert report (“Shumer Rep.”). The *curriculum vitae* attached to my initial expert report remains true, correct and up to date.

4. I hereby provide a rebuttal report to respond to the expert reports provided by the Defendants. This report is provided after my review of reports

submitted by Drs. Michael K. Laidlaw, Stephen B. Levine, James M. Cantor, and Geeta Nangia.

5. In preparing this rebuttal report, I have relied on my training and years of research and clinical experience, as set out in my *curriculum vitae* (attached as **Exhibit A** to my original report) and on the materials listed therein; the materials listed in the bibliography attached as **Exhibit B** to my original report; and the additional materials listed in the supplemental bibliography attached as **Exhibit C** to this rebuttal report. The sources cited in each of these are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject, which include authoritative, scientific peer-reviewed publications.

6. I reserve the right to revise and supplement the opinions expressed in this report 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 and issues that may arise in my area of expertise. I may also further supplement these opinions in response to information produced by Defendants in discovery and in response to additional information from Defendants' designated experts.

DEFENDANTS’ EXPERT OPINIONS LACK A SCIENTIFIC FOUNDATION AND CONTRADICT EVIDENCE-BASED STANDARDS OF CARE AND PRACTICE GUIDELINES FOR THE TREATMENT OF TRANSGENDER ADOLESCENTS

7. Defendants’ expert declarations demonstrate a basic lack of understanding of the nature, evaluation, and treatment of gender dysphoria, the serious consequences of the condition if left untreated, and the strength of the evidence in support of medical management of gender dysphoria, including the efficacy and safety of these treatments. Defendants’ experts have limited or no experience with diagnosis and treatment of gender dysphoria. Their opinions are not consistent with current evidence-based standards of care or practice guidelines for the treatment of gender dysphoria in minors.

I. The WPATH Standards of Care and the Endocrine Society Guidelines were Derived from Rigorous Scientific Review of all Available Studies on the Safety and Efficacy of Gender Transition Care for Adolescents

8. Studies have repeatedly documented that pubertal suppression and hormone therapy are safe and effective treatments for transgender adolescents with gender dysphoria.¹ These articles represent a small percentage of the full body of

¹ See, e.g., Diana M. Tordoff, et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5 *Jama Network Open* 1 (2022) (finding that receipt of medical care, including puberty blockers and gender-affirming hormones, was associated with 60% lower odds of moderate or severe depression and 73% lower odds of suicidality over a 12-month follow-up); Amy E. Green, et al., *Association of Gender-Affirming Hormone Therapy with*

literature that was utilized to create evidence-based clinical practice guidelines for the treatment of gender dysphoria in children, adolescents, and adults. These

Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth, 70 J. Adolescent Health 643, 647 (2022) (finding that use of hormone therapy during adolescence was associated with lower odds of recent depression and having attempted suicide in the past year); Jack L. Turban, et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 Pediatrics 1 (2020) (finding that access to puberty blockers during adolescence is associated with a decreased lifetime incidence of suicidal ideation among adults); Christal Achille, et al., *Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: Preliminary results*, Int'l J. Pediatric Endocrinology 1 (2020) (finding that endocrine intervention was associated with decreased depression and suicidal ideation and improved quality of life for transgender youth); Laura E. Kuper, et al., *Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy*, 145 Pediatrics 1 (Apr. 2020) (showing hormone therapy in youth is associated with reducing body dissatisfaction and improvements in mental health); Anna I.R. van der Miesen, et al., *Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers*, 66 J. Adolescent Health 699 (June 2020) (showing fewer emotional and behavioral problems after puberty suppression and similar or fewer problems compared to same-age non-transgender peers); Rosalia Costa, et al., *Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria*, 12 J. Sexual Med. 2206 (Nov. 2015) (finding significantly increased psychosocial functioning after twelve months of puberty suppression); Annelou L.C. de Vries, et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014) (following a cohort of transgender young people in the Netherlands from puberty suppression through surgical treatment and finding that the cohort had global functioning equivalent to the Dutch population).

treatments alleviate the increased distress and dysphoria caused by the physical changes accompanying puberty. Hormone therapy also brings a transgender person's body into greater alignment with their identity and reduces the number of surgeries a transgender person may need as an adult.²

9. These clinical practice guidelines were published by long-standing and well-respected professional 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). Other leading medical bodies—including the American Association of Pediatrics (AAP), the American Medical Association (AMA), the American Psychological Association, the American Psychiatric Association, and the American Academy of Family Physicians (AAFP)—all support these guidelines due to the rigorous nature of their review of scientific evidence in the field (Rafferty, et al., 2018 (AAP), AMA, 2019; American Psychological Association, 2015; Drescher, et al., 2018 (American Psychiatric Association); Klein, et al., 2018 (AAFP)).

² de Vries ALC, McGuire JK, Steensma et al., Young adult psychological outcome after puberty suppression and gender reassignment. 134 *Pediatrics* 696-704 (Oct. 2014).

10. Defendants’ experts’ criticisms of the process used to develop the WPATH Standards of Care and the Endocrine Society Guidelines are unfounded. Both were created based on rigorous reviews of the best available science and expert professional consensus in transgender health. For WPATH, international professionals were selected to serve on the SOC 8 writing committee. Recommendation statements were developed based on data derived from independent systematic 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).

11. Similarly, the Endocrine Society 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.” (Hembree et al. 2017). The Endocrine Society published its clinical practice guidelines in collaboration with the Pediatric Endocrine Society, the European Societies for Endocrinology and Pediatric Endocrinology, and WPATH, among others. (Hembree et al. 2017).

12. Dr. Cantor spends more than 10 pages of his declaration discussing the “Pyramid of Standards of Evidence” to support his claim that the evidence

supporting puberty suppression and hormone therapy is not based on randomized controlled trials and is therefore not reliable. (Cantor Decl. ¶¶ 37–67.) Drs. Laidlaw and Levine also base much of their criticism of medical treatments for transgender adolescents on the absence of randomized controlled trials (*See, e.g.*, Laidlaw Decl. ¶¶ 76, 117, 204, 233, 265; Levine Decl. ¶¶ 132, 133, 232). While I agree that randomized control trials are an excellent study design in many contexts, such trials are not ethically permissible for treatments that are already known to provide a benefit to patients, which includes the use of GnRHa and hormone therapy to treat gender dysphoria in adolescents.³ For this reason, no such study of these treatments would be approved, no patients and families would participate, and no ethical researcher would undertake such a study. Therefore, as is true for most other pediatric treatments, researchers in this field must rely on other types of study design, such as longitudinal cohort studies, which monitor change in symptoms over the course of treatment (de Vries ALC, 2014), or cross-sectional studies comparing treated and untreated persons (Turban, 2022).

³ Sari L. Reisner, et al., *Advancing Methods for U.S. Transgender Health Research*, 23 *Current Opinion in Endocrinology & Diabetes and Obesity* 198 (Apr. 2016); *see also* R.J. Lilford & J. Jackson, *Equipose and the Ethics of Randomization*, 88 *J. of the Royal Soc’y of Med.* 552 (Oct. 1995).

II. Medical Care for Transgender Adolescents Is Safe and Effective, and Defendants' Experts' Assertions to the Contrary are Without Merit

13. Defendants' experts devote much of their declarations to criticizing the wealth of evidence that medical care is beneficial in the treatment of gender dysphoria among transgender adolescents. These criticisms are not well-founded.

14. For example, Dr. Cantor contends that studies showing that transgender adolescents benefit from medical treatments have "major methodological limitations" and attempts to discredit individual studies (Cantor Decl. ¶97). What Dr. Cantor ignores is that all studies in the medical and scientific fields have limitations. Indeed, studies in many other areas of clinical medicine have similar methodological limitations, and highlighting these limitations is a critical element of reporting biomedical research.⁴ Medical journals instruct authors to highlight limitations of their studies as a prerequisite for publication.⁵ Those limitations do not mean that the studies are dismissed out of hand. To the contrary, each study contributes to the collective knowledge base and health care providers look at the

⁴ Milo A. Puhan, et al., *Discussing study limitations in reports of biomedical studies- the need for more transparency*, 10 Health and Quality of Life Outcomes 1 (2012).

⁵ JAMA, "Instructions for Authors," available at <https://jamanetwork.com/journals/jama/pages/instructions-for-authors> : :text A 20list 20of 20 20Key,5 20tables 20and 2For 20figures (last visited June 15, 2023).

entire body of evidence – as well as their own clinical experience and that of their colleagues – to inform their approach to treatment.

15. Similarly, Dr. Levine cites a 2015 article by the American Academy of Child and Adolescent Psychiatry Committee on Quality Issues to support his claim that “[p]rominent voices in the field of gender dysphoria have emphasized the severe lack of scientific knowledge in this field.” (Levine Decl. ¶132).⁶ The article does not support this claim. **First**, the text Dr. Levine quotes refers to the treatment of *prepubertal* children, not to transgender adolescents, and thus has no bearing on the treatments banned by Kentucky’s law, which are prescribed only for post-pubertal youth. **Second**, even with respect to prepubertal children, the text Dr. Levine cites cautions *against* the approach to prepubertal children that Dr. Levine and Defendants’ other experts support—namely to subject such children to counseling and other interventions designed to reduce or eliminate their cross-gender identification or gender nonconformity. The article cautions against such an approach, noting: “[T]he possible risk that children may be traumatized by disapproval of their gender discordance must be considered. Just as family rejection

⁶ Stewart L. Adelson & American Academy of Child and Adolescent Psychiatry, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51 J. Am. Acad. of Child & Adolescent Psychiatry 957 (2012).

is associated with problems such as depression, suicidality, and substance abuse in gay youth, the proposed benefits of treatment to eliminate gender discordance in youth must be carefully weighed against such possible deleterious effects.”⁷ **Third**, the article *supports* medical treatment for transgender adolescents, concluding that “such treatment may be in the best interest of the adolescent when all factors, including reducing psychiatric comorbidity and the risk of harm from illicit hormone abuse, are considered.”⁸ And **finally**, AACAP unequivocally opposes bans on medical treatment for transgender youth, stating: “The American Academy of Child and Adolescent Psychiatry (AACAP) supports the use of current evidence-based clinical care with minors. AACAP strongly opposes any efforts – legal, legislative, and otherwise – to block access to these recognized interventions,” including “social gender transition, hormone blocking agents, hormone treatment, and affirmative psychotherapeutic modalities.”⁹

⁷ Adelson, *supra* n.6, at 969.

⁸ *Id.* at 970

⁹ American Academy of Child and Adolescent Psychiatry, *AACAP Statement Responding to Efforts to ban Evidence-Based Care for Transgender and Gender Diverse Youth* (Nov. 8, 2019), available at https://www.aacap.org/AACAP/Latest_News/AACAP_Statement_Responding_to_Efforts-to_ban_Evidence_Based_Care_for_Transgender_and_Gender_Diverse.aspx (last visited June 15, 2023).

16. Defendants' experts focus much of their reports on dismissing the known benefits of gender transition-related medical treatment on suicidality and other mental health outcomes. For example, Dr. Cantor critiques 2011 and 2014 studies by de Vries, et al., which demonstrated that patients with gender dysphoria had improved behavioral and emotional outcomes and depressive symptoms after receiving medical treatment for their gender dysphoria. Dr. Cantor suggests that because the participants were also receiving psychological support, it is not possible to know if it was medical treatment or psychological support which caused the improvement in mental health symptoms (Cantor Decl. ¶188). He misunderstands that supportive care does not mean drugs alone, but rather a constellation of medical treatment and psychosocial support. Separating these aspects of care does not make sense clinically. In my view, the findings in these two studies provide strong evidence in favor of gender affirming treatment.

17. Similarly, Dr. Laidlaw falsely claims that a 2011 study about transgender adults (Dhejne, et al., 2011) shows that medical treatments for transgender adolescents do not reduce suicidality. Dr. Cantor cites this study for the proposition that undergoing sex-reassignment surgery does not decrease suicidality among transgender adults. (Laidlaw Decl. ¶203). In fact, as the lead author of the study has cautioned, the study did not examine this issue and does not support that

conclusion,¹⁰ much less does it shed any light on the efficacy of hormonal treatments for transgender adolescents in reducing suicidality.

18. Drs. Cantor, Levine, and Nangia also misrepresent the Dhejne study and other studies addressing suicidality among transgender people, falsely claiming that there is no evidence that medical treatment reduces suicidality among transgender adolescents. (Cantor Decl. ¶¶146-152; Levine Decl. ¶¶152-168; Nangia Decl. ¶¶133, 152). In fact, multiple studies demonstrate this positive impact, which is also consistent with my own clinical practice.¹¹

19. Defendants' experts also misstate the risks and benefits associated with GnRHa and hormone therapy. (Cantor Decl. at Sections XII and XIV; Levine Decl. ¶¶169-98)

20. The concerns raised by Defendants' experts about bone density in patients prescribed GnRHa are well-known, generally short-lived, and are specifically managed during patient care. In practice, risk of lower bone mineral

¹⁰ Cecilia H. Dhejne, *Science AMA Series: I'm Cecilia Dhejne a fellow of the European Committee of Sexual Medicine, from the Karolinska University Hospital in Sweden. I'm here to talk about transgender health, suicide rates, and my often misinterpreted study. Ask me anything!*, Winnower 10:e150124.46274 (2017).

¹¹ See, e.g., Diana M. Tordoff, et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5 JAMA Network Open (2022); Amy E. Green, et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 7 J. Adolescent Health 643–649 (2022).

density is 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). It is accurate to state that pubertal hormones (either testosterone or estrogen) contribute to bone density accrual. A person who was never exposed to any sex hormones for their entire life would be at high risk of osteoporosis. GnRHa, however, is administered only for a relatively short period of time. Once a decision is made to either administer gender-affirming hormones or to resume puberty consistent with a patient's birth-assigned sex, bone density accrual rises with exposure to those sex hormones.

21. Dr. Laidlaw's concerns about bone density in patients prescribed GnRHa are likewise overblown, if not wholly unfounded (Laidlaw Decl. ¶¶ 98-108). It is not surprising that the Carmichael study referenced (Laidlaw Decl. ¶ 102-03) found that there is a reduction in Z-scores in adolescents on GnRHa aged 12-15 during the time of treatment when compared to age-matched controls. What is misleading, however, is that these patients will be transitioned off GnRHa when a decision is made regarding treatment with gender-affirming hormones or to resume puberty consistent with their birth-assigned sex. After exposure to sex hormones, bone density accrual will rise and go back to normal levels for the patient's age. In practice, risk of lower bone mineral density is 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).

22. Dr. Cantor and Dr. Laidlaw raise a hypothetical concern regarding brain development, suggesting that somehow use of GnRHa has “unknown, but likely negative consequences ... with respect to brain development” (Laidlaw Rep. ¶108; Cantor Decl. ¶¶208-12). While it is common for researchers and clinicians to consider any possible adverse impacts of medications, there is no evidence that puberty blockers have any adverse impact on brain development. For example, when considering children with naturally occurring delayed puberty, I find no published evidence of negative consequences to brain development compared with children with normally timed puberty. Likewise, Dr. Cantor and Dr. Laidlaw can point to no published evidence in support of this concern in transgender adolescents prescribed GnRHa, instead citing various articles that simply raise the issue. There are also studies related to children who are prescribed GnRHa for precocious puberty that found that “GnRHa treated girls do not differ in their cognitive functioning ... from the same age peers.” (Wojniusz et al. 2016). The authors of this article came to this conclusion because there was not a statistically significant difference in IQ, memory, mental rotation, cognitive executive function, processing speed,

attention, or executive function in participants treated with GnRHa for precocious puberty.

III. Gender Identity Has a Strong Biological Foundation

23. Dr. Cantor asserts that I have not provided sources showing that gender identity “has a strong biological foundation.” (Cantor Decl. ¶264). 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). 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 similar to the volume found in non-transgender women (topic reviewed in Chung et al. 2002).

24. 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).

25. 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).

26. 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).

27. 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).

28. Dr. Cantor discounts gender identity on the basis that there is “no means of either falsifying or verifying people’s declarations of their gender identities.” (Cantor Decl. ¶104). He also claims “[i]n science, it is the objective factors—and only the objective factors—that matter to a valid definition.” (Cantor Decl. ¶104). But just because gender identity is a human characteristic ascertained through observation and conversations rather than a lab test makes it no less valid or “scientific.” Gender identity is a real human characteristic, and it is rooted in biology.

29. Dr. Laidlaw incorrectly claims that that gender dysphoria is not an endocrine condition and should not be treated with medication because it cannot be diagnosed through a laboratory test. (Laidlaw Decl. ¶¶ 19-21, 43-51). First, there is ample scientific evidence that gender identity has a strong biological foundation (Shumer Rep. ¶¶ 28-32). Second, endocrinologists are uniquely suited to treat gender dysphoria due to familiarity with prescribing and monitoring medications such as GnRHa, testosterone, and estrogen. Third, countless medical conditions are

diagnosed with clinical observation and questioning rather than with a laboratory test, an imaging test, or examination of cells under a microscope (e.g., migraines, neuropathic pain, Alzheimer’s disease, irritable bowel syndrome, fibromyalgia), but are no less actual medical diagnoses which improve with medical interventions. Fourth, the American Board of Internal Medicine requires knowledge of gender dysphoria and its management in order to become certified as an Endocrinologist (American Board of Internal Medicine, 2023). Ultimately, while I disagree with Dr. Laidlaw’s discomfort with classification of gender dysphoria as an endocrine disorder, this debate is mere semantics and not pertinent to the appropriate assessment and management of the condition.

IV. The Rates of “Desistance” Among Transgender Adolescents Is Extremely Low

30. Dr. Laidlaw correctly points out that the number of young people being referred to the Gender Identity Development Service in the UK has increased significantly over time (Laidlaw Decl. ¶ 209; *see also* Levine Rep. ¶128) but wrongly attributes this increase to “social contagion” and “social media/internet use.” I would suggest an alternative explanation that is not only more likely, but also supported by research. As transgender individuals face less cultural stigma than in previous generations, young people understand that they will be supported and

valued by their family and community and are more likely to explore and discuss gender identity openly (Zhang, et al., 2020). Two unrelated examples may make this concept more understandable. First, it should come as no surprise that the rate of openly gay individuals is lower in countries that criminalize homosexuality. Would you suppose that it is more likely that citizens of country X, which criminalizes homosexuality, has very few openly gay citizens because there is naturally a very low rate of homosexuality in that country, or because gay citizens fear retribution for coming out as gay? Second, in many societies left-handed people have been historically encouraged as children to use their right hands for writing and other fine-motor skills. However, in the late 20th century, left-handedness became less stigmatized and the percentage of left-handed people tripled, rose from about 4 percent in 1920 to 12 percent (McManus 2009).

31. In addition, not all adolescents who present for treatment ultimately go on to receive medical interventions. In fact, in a large study from the Netherlands, the percentage of transgender people presented for evaluation who actually received any type of medical treatment has decreased over time.¹² The authors of that study note: “[T]his finding may be explained by the fact that in the past it was harder to

¹² C.M. Wiepjes, et al., *The Amsterdam cohort of gender dysphoria study (19 2 2015): trends in prevalence, treatment, and regrets*, 15 J. of Sexual Med. 582-590 (2018).

find information about [gender dysphoria] and its treatment, and only people with extreme types of [gender dysphoria] managed to visit our gender identity clinic for treatment. Currently, owing to media attention and the internet, it is easier to access information about our gender identity clinic, making the threshold lower to search for help.”¹³

32. Dr. Laidlaw asserts that rates of “desistance” are very high and therefore treatments as outlined by current standards of care will cause serious and irreversible harm to children and adolescents (Laidlaw Rep. ¶¶ 169, 212-15). This fallacy, repeated by many opponents of gender affirming care, misrepresents the data completely. As outlined in my report (Shumer Rep. ¶ 58), it is true that the majority of prepubertal gender diverse children exploring their gender do not develop gender dysphoria and are not expected to become transgender adolescents or adults, but that is because they are not transgender in the first place. First, the diagnostic criteria of “Gender Identity Disorder in Children,” which no longer exists as a diagnosis, and “Gender Dysphoria in Children” which is the current diagnosis, are distinct. The former, which included a significantly broader group of children, was the one in place at the times the studies to which Dr. Laidlaw cites occurred, and thus included many children who were simply gay or gender-nonconforming. Second, while Dr.

¹³ *Id.*

Laidlaw attempts to cite data from studies of children across wide age groups, age 3-13 in one instance, he does not attempt parse out important clinical information such as the age and pubertal stage of so-called “desisters” in these studies. (Laidlaw Decl. ¶ 215). Lastly, because prepubertal children are not treated with hormonal medications for gender dysphoria, citing these studies has no relevance to the question of how to treat adolescents. Children whose gender dysphoria persists into adolescence are highly likely to be transgender (van der Loos, et al., 2022).

33. Dr. Laidlaw also wrongly suggests that the use of pubertal suppression alters the natural course of “desistance” claiming that receiving this medication causes children who would otherwise “desist” to become transgender. (Laidlaw Decl. ¶¶ 213). Here Dr. Laidlaw is making a causal theory error – making a claim of causation based on correlational evidence. Children with persisting gender dysphoria into puberty (1) are very likely to have persisting gender dysphoria into adulthood, and (2) are eligible for treatment with GnRHa. The use of GnRHa is not actually influencing future gender identity. In other words, the fact that patients prescribed pubertal suppression are likely to later be prescribed gender affirming hormones indicates that clinicians are correctly identifying patients who have gender dysphoria and benefit from medical intervention.

V. Dr. Laidlaw Mischaracterizes The Risks and Benefits of Hormonal Treatments for Gender Dysphoria

34. Dr. Laidlaw's report correctly defines a medical condition, *hypogonadotropic hypogonadism*, as a condition in which the pituitary fails to send signals to the gonads (Laidlaw Decl. ¶ 79). Dr. Laidlaw then describes gender affirmative therapy (specifically, pubertal suppression) as deliberately causing the medical condition *hypogonadotropic hypogonadism* and then, based on a limited review of some of the plaintiffs medical records, declares that the plaintiffs have developed *hypogonadotropic hypogonadism* as a result of their medical care (Laidlaw Decl. ¶¶ 64-70, 76, 86, 242, 253). In his report, Dr. Laidlaw described the use of GnRHa in treatment of prostate cancer and precocious puberty. Notably, he did not frame GnRHa as causing the medical condition *hypogonadotropic hypogonadism* in those patients but described the use of GnRHa as effective treatment for these other conditions. He ignores that GnRHa is also an effective treatment for gender dysphoria. By conflating the goal of therapy (suppression of sex hormone production) with causing a medical condition (*hypogonadotropic hypogonadism*) in one instance, but not others, is inappropriate if not disingenuous.

35. Dr. Laidlaw repeats this same wordplay tactic in describing the administration of testosterone as inducing *hyperandrogenism* in transgender men

(Laidlaw Decl. ¶¶ 117, 125-32), and administration of estrogen as inducing *hyperestrogenism* in transgender women (Laidlaw Decl. ¶¶ 143-51). He describes the use of testosterone to treat gender dysphoria in transgender male plaintiffs as inducing *hyperandrogenism* and speculates that JM2, a transgender boy, is at risk for severe *hyperandrogenism* due to the “high dose of testosterone” he has been prescribed (Laidlaw Decl. ¶¶ 243-47).

36. In reality, when testosterone is prescribed for gender dysphoria as for the transgender male plaintiffs, the goal is to achieve a normal male testosterone level based on age, meaning a testosterone level that is consistent with the normal testosterone levels for cisgender males of similar age; when estrogen is prescribed for gender dysphoria as it is for transgender females, the goal is to achieve a normal female estrogen level based on age, meaning an estrogen level that is consistent with the normal estrogen levels for cisgender females of similar age. These goals mirror what Dr. Laidlaw or any other endocrinologist would aim for when treating low testosterone or ovarian failure (Laidlaw Decl. ¶¶ 117, 143).

37. Dr. Laidlaw frames evidence-based treatments for gender dysphoria as causing medical conditions, rather than acknowledging the similarity in how these medications are used in different contexts. The underlying premise of Dr. Laidlaw’s

opinions seems to be that gender dysphoria is not a legitimate diagnosis worthy of any medical treatment and that there should not be any transgender people.

38. Dr. Laidlaw also misrepresents the risks of using the hormone *testosterone* to treat gender dysphoria (Laidlaw Decl. ¶¶ 115-124). He correctly explains that when treating men with testosterone deficiency, the dose of testosterone must be carefully considered and monitored to avoid excess levels (Laidlaw Rep. ¶ 116). This is equally true when using testosterone for treatment of gender dysphoria. He mentions that some individuals abuse testosterone by taking more than prescribed, but it is unclear if he is implying that transgender men would be more likely to do this than others, which I would not expect and find no data to support. All of the adverse effects of excessive testosterone that Dr. Laidlaw avoids by carefully monitoring his patients with low testosterone (e.g., increased libido, headache, erythrocytosis) are similarly avoided by careful monitoring in transgender men.

39. Dr. Laidlaw also appears to argue that transgender men can develop erythrocytosis (elevation in the red blood cell measurement, hematocrit) while being treated with testosterone (Laidlaw Decl. ¶ 140-42). Dr. Laidlaw is using the female reference range for hematocrit to make this assertion, again considering these patients as females with *hyperandrogenism* rather than transgender men receiving

evidence-based care for gender dysphoria. This is inappropriate; the male reference range for hematocrit should be used for patients on testosterone treatment (Deutch, 2016).

40. Dr. Laidlaw makes parallel arguments regarding estrogen (Laidlaw Decl. ¶¶143-51) by pointing out the elevated estrogen can be associated with health problems, while ignoring that the goal of treatment with estrogen in gender dysphoria is maintenance of estrogen levels in the normal female range. Risk for the health concerns he highlights are avoided by careful monitoring in transgender women.

41. He states that the risk for breast cancer increases when a “male” is treated with “high dose estrogen” (Laidlaw Decl. ¶ 150). This misunderstands the risks. It is of course not surprising that transgender women with breasts are at higher risk for breast cancer than men without breasts. What Dr. Laidlaw leaves out of his discussion is the complete findings of the Christel article referenced. That article found that despite an increased risk of breast cancer in transgender women compared with cisgender men, there was a lower risk when compared to cisgender women. The article concluded that “breast cancer screening guidelines for cisgender people are sufficient for transgender people using hormone treatment” (Christel, 2019).

42. Dr. Laidlaw would argue that risks of gender affirming care outweigh the benefits. He is incorrect; he has provided grossly exaggerated and erroneous description of risk while completely discounting the benefits of treatment or the risks of withholding treatment.

VI. Parents Are Capable of Providing Informed Consent And Patients of Providing Informed Assent To Medical Treatments for Adolescent Gender Dysphoria, Including Weighing Concerns about Fertility

43. In the context of gender affirming care, concerns about fertility are discussed with adolescent patient and their families when receiving both GnRHa as treatment and/or gender-affirming hormones. Indeed, SOC 8 recommends that “health care professionals working with transgender and gender diverse adolescents requesting gender-affirming medical or surgical treatments inform them, prior to initiating treatment, of the reproductive effects including the potential loss of fertility and available options to preserve fertility within the context of the youth's stage of pubertal development.” (Coleman, et al., 2022).

44. It is important to note that Dr. Laidlaw also misconstrues the effect of GnRHa on fertility. As outlined in my prior report, GnRHa treatments do not have long-term implications on fertility (Shumer Decl. ¶64). Dr. Laidlaw correctly explains that giving GnRHa to a four-year-old with precocious puberty will not

impair fertility. (Laidlaw Decl. ¶73). Likewise, GnRHa will also have no effect on fertility when used in older transgender adolescents.

45. What is more, for transgender adolescents taking GnRHa and for whom hormones appears to be indicated as treatment, fertility preservation can be offered after a brief cessation of GnRHa treatment but before hormones. Case reports illustrate the success of this approach in fertility preservation. (Martin, et al., 2021; Rothenberg, et al., 2019).

46. Even if gender affirming hormones were introduced following use of GnRHa, these hormones could be discontinued with a goal of progression through internal puberty and achieving fertility. Withdrawal of hormones in adulthood often is successful in achieving fertility when it is desired (Light, et al., 2014; Knudson, et al., 2017).

47. Dr. Laidlaw also raises concerns about future sexual function in patients prescribed GnRHa (Laidlaw Decl. ¶¶ 96-97). In my experience, it is essential to have open, age-appropriate discussions around sex and sexuality while respecting that all persons, including transgender people, are diverse in terms of sexual orientation and desires. Sexuality and sexual function should be considered and maximized as transgender patients reach adulthood. In this context, it should not be underestimated how a positive body image is also associated with better sexual function and

satisfaction. Additionally, research clearly shows that persons with untreated gender dysphoria may have significant challenges with sexuality and sexual function (Holmberg, 2019).

48. Dr. Laidlaw argues that it is not possible for parents to make a truly informed consent decision regarding medical care for gender transition, and suggests, without reasoning or evidence, that this decision is somehow different than other complex medical decisions that parents and guardians make regarding the health and wellness of their children every day. In my experience as a pediatrician working with children and families every day, Dr. Laidlaw is severely underestimating the capacity of parents and guardians to understand and balance information pertaining to the health of their children. He also ignores that WPATH SOC 8 clearly outlines criteria for how providers obtain assent and consent for medical intervention (Coleman, et al., 2022).

49. As a pediatric endocrinologist when assessing any patient for any condition, my job is to analyze all available information, determine an appropriate diagnosis, and then discuss potential treatment options with patients and parents. This is true regardless of whether I am seeing the patient for gender concerns, slow growth, thyroid disease, or diabetes. Providers of gender affirming care rely upon

the well-established and evidence-based standards of care for assessment, diagnosis, and management of gender dysphoria.

VII. Defendants’ Experts’ Mischaracterize International Medical Practices Regarding Gender Transition

50. Defendants’ experts’ declarations refer to documents from several other countries on the treatment of gender dysphoria, predominantly from Finland, Sweden, and the United Kingdom (“UK”), although they also mention documents from France and Norway.

51. Before addressing the substance of their claims related to these documents, several preliminary points should be made. Defendants’ experts do not provide a comprehensive review of international practices but rather selectively cite documents they believe support their position.

52. Language differences also make it difficult to fully assess some of the material that Defendants’ experts cite to as support for their claims. For example, the Swedish National Board of Health and Welfare’s (NBHW) guideline for the care of children and adolescents with gender dysphoria is not available as an official English translation; only a six-page summary is available.¹⁴

¹⁴ The National Board of Health and Welfare, *Care of Children and Adolescents with Gender Dysphoria: Summary* (2022), <https://www.socialstyrelsen.se/globalassets/sharepoint->

53. With respect to the content of these documents, none is a clinical practice guideline which rates the quality of the evidence and the strength of the recommendations. Some of the documents are systematic reviews of the literature that rate the quality of the evidence but do not make recommendations.¹⁵ Direct inferences cannot be drawn from the quality of the evidence to the strength of recommendations; low quality evidence may be a sufficient basis for strong recommendations. The French document referenced is in fact only a press release.¹⁶

54. Dr. Cantor mischaracterizes the conclusions of these documents, stating for example that they “range from medical advisories to outright bans on the medical transition of minors.” (Cantor Decl. ¶16). None of the documents to which Dr. Cantor refers recommend banning medical care for treating gender dysphoria in adolescents.

dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf (last accessed June 15, 2023).

¹⁵ National Institute for Health and Care Excellence (NICE), *Evidence Review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria* (2020), available at <https://cass.independent-review.uk/nice-evidence-reviews/> (last accessed June 15, 2023).

¹⁶ Académie Nationale de Médecine, *Medicine and gender transidentity in children and adolescents* (2022), available at <https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en> (last accessed June 15, 2023).

55. Finland, Sweden, and the UK are all moving to providing care through regional multidisciplinary clinics, the type of care commonly provided in the United States.¹⁷ In Finland, for example, medical care is provided by Helsinki University Central Hospital and Tampere University Hospital. Puberty suppression and hormone treatment are provided to minors with persistent gender dysphoria on a case-by-case basis.¹⁸

56. Sweden is restructuring care for gender dysphoria into three national specialized medical care units. While the Swedish recommendations state puberty suppression and gender-affirming hormone treatment “should be offered only in exceptional cases,” they later state that “an early (childhood) onset of gender incongruence, persistence of gender incongruence until puberty and a marked

¹⁷ Sam Hsieh & Jennifer Leininger, *Resource list: Clinical care programs for gender-nonconforming children and adolescents*, 43 *Pediatric Annals* 238–244 (2014).

¹⁸ Council for Choices in Health Care in Finland, *Medical treatment methods for dysphoria associated with variations in gender identity in minors recommendation* (2020), available at [https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en \(1\).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en \(1\).pdf?t=1631773838474](https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en%20(1).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en%20(1).pdf?t=1631773838474) (last accessed June 15, 2023).

psychological strain in response to pubertal development is among the recommended criteria.”¹⁹

57. The United Kingdom is moving from a single specialist provider model to regional centers in order to better meet the need for expanded care. The Cass Review encourages providers prescribing puberty suppressants and hormone therapy to follow the Endocrine Society Guidelines and UK guidelines regarding informed consent.²⁰

58. The documents all emphasize the importance of data collection. The Cass Review recommends, for example, “[e]xisting and future services should have standardized data collection in order to audit standards and inform understanding of the epidemiology, assessment and treatment of this group of children and young people.”²¹

59. The Swedish NBHW similarly states, “[t]o ensure that new knowledge is gathered, the NBHW further deems that treatment with GnRH-analogues and sex hormones for young people should be provided within a research context, which

¹⁹ The National Board of Health and Welfare, *supra* n.20, at 4.

²⁰ Hilary Cass, *The Cass Review: Independent Review of Gender Identity Services for Children and Young People Interim Report*, National Health Service (NHS), UK at 71–72 (2022).

²¹ *Id.*

does not necessarily imply the use of randomized controlled trials (RCTs). As in other healthcare areas where it is difficult to conduct RCTs while retaining sufficient internal validity, it is also important that other prospective study designs are considered for ethical review and that register studies are made possible.”²²

60. In sum, the countries cited by Defendants’ experts continue to provide medical treatments for transgender adolescents, with an emphasis on careful evaluation and data collection. None of the countries cited by Defendants’ experts have banned these treatments, as Kentucky has done.

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

Executed on June 16, 2023.



Daniel Shumer, M.D.

²² The National Board of Health and Welfare, *supra* n.20.

Exhibit C
Supplemental Bibliography

BIBLIOGRAPHY

Académie Nationale de Médecine, *Medicine and gender transidentity in children and adolescents* (2022), available at <https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en> (last accessed June 15, 2023).

Achille, C., et al., *Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: Preliminary results*, *Int'l J. Pediatric Endocrinology* 1 (2020)

Adelson, S.L. & American Academy of Child and Adolescent Psychiatry, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51 *J. Am. Acad. of Child & Adolescent Psychiatry* 957 (2012).

American Academy of Child and Adolescent Psychiatry, *AACAP Statement Responding to Efforts to ban Evidence-Based Care for Transgender and Gender Diverse Youth* (Nov. 8, 2019), available at https://www.aacap.org/AACAP/Latest_News/AACAP_Statement_Responding_to_Efforts-to_ban_Evidence_Based_Care_for_Transgender_and_Gender_Diverse.aspx (last visited June 15, 2023).

American Board of Internal Medicine: Endocrinology, Diabetes, and Metabolism Certification Examination Blueprint (2023), available at <https://www.abim.org/Media/wxbjt5o3/endocrinology-diabetes-metabolism.pdf>.

American Medical Association and GLMA, *Health Insurance Coverage for Gender-Affirming Care of Transgender Patients* (2019), available at <https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf>

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

Berglund, H., Lindström, P., Dhejne-Helmy, C., & Savic, I. (2008). Male-to-female transsexuals show sex-atypical hypothalamus activation when smelling odorous steroids. *Cerebral cortex* (New York, N.Y. : 1991), 18(8), 1900–1908.

Cass, H. *The Cass Review: Independent Review of Gender Identity Services for Children and Young People Interim Report*, National Health Service (NHS), UK at 71–72 (2022).

Chung, W. C., De Vries, G. J., & Swaab, D. F. (2002). Sexual differentiation of the bed nucleus of the stria terminalis in humans may extend into adulthood. *The Journal of neuroscience: the official journal of the Society for Neuroscience*, 22(3), 1027–1033.

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.* 2022 Sep 6;23(suppl 1):S1-S259.

Coleman E, Bockting W, Botzer M. et al. *Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7.* (2012) *International Journal of Transgenderism.* 13. 165-232.

Costa, R., et al., *Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria*, 12 *J. Sexual Med.* 2206 (Nov. 2015).

Council for Choices in Health Care in Finland, *Medical treatment methods for dysphoria associated with variations in gender identity in minors recommendation* (2020), available at [https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en \(1\).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en \(1\).pdf?t 1631773838474](https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en (1).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en (1).pdf?t 1631773838474)

Deutsch, MB (ed.). *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people*, University of California, San Francisco, Department of Family and Community Medicine Center of Excellence for Transgender Health, (2nd ed. 2016), available at <https://transcare.ucsf.edu/sites/transcare.ucsf.edu/files/Transgender-PGACG-6-17-16.pdf>

de Vries, A.L.C., et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 *Pediatrics* 696 (2014).

de Vries, A. L. C., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T., *Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study*, 8 *J. of Sexual Med.* 2276–2283 (2011).

Dhejne C, Lichtensetin P, Boman M, et al., *Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden*. 6 *PLoS One* e16885 (Feb. 2011).

Dhejne, C.H. *Science AMA Series: I'm Cecilia Dhejne a fellow of the European Committee of Sexual Medicine, from the Karolinska University Hospital in Sweden. I'm here to talk about transgender health, suicide rates, and my often misinterpreted study. Ask me anything!*, *Winnower* 10:e150124.46274 (2017).

Dessens, A. B., Slijper, F. M., & Drop, S. L. (2005). Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia. *Archives of sexual behavior*, 34(4), 389–397.

Drescher, J., Haller, E., & Yarbrough, E., *Position statement on access to care for transgender and gender diverse individuals. Caucus of LGBTQ Psychiatrists and the Council on Minority Mental Health and Health Disparities*, American Psychiatric Association (2018).

Green, A., et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 7 *J. Adolescent Health* 643–649 (2022).

Luders, E., Sanchez, F. J., Gaser, C., Toga, A. W., Narr, K. L., Hamilton, L. S., & Vilain, E. (2009). Regional gray matter variation in male-to-female transsexualism. *NeuroImage*, 46(4), 904–907.

Hembree, W.C., Cohen-Kettenis, P.T., Gooren, L., et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 *J. Clin. Endocrinology & Metabolism* 3869–3903 (2017).

Henningsson, S., Westberg, L., Nilsson, S., Lundström, B., Ekselius, L., Bodlund, O., Lindström, E., Hellstrand, M., Rosmond, R., Eriksson, E., & Land n, M.

(2005). Sex steroid-related genes and male-to-female transsexualism. *Psychoneuroendocrinology*, 30(7), 657–664.

Heylens, G., De Cuypere, G., Zucker, K. J., Schelfaut, C., Elaut, E., Vanden Bossche, H., De Baere, E., & T'Sjoen, G. (2012). Gender identity disorder in twins: a review of the case report literature. *The journal of sexual medicine*, 9(3), 751–757.

Holmberg M., Arver S., Dhejne C., *Supporting sexuality and improving sexual function in transgender persons*. 16 *Nat. Rev. Urol.* 121-139 (Feb. 2019).

Hsieh, S. & Leininger, J., *Resource list: Clinical care programs for gender-nonconforming children and adolescents*, 43 *Pediatric Annals* 238–244 (2014).

JAMA, “Instructions for Authors,” available at <https://jamanetwork.com/journals/jama/pages/instructions-for-authors> : :text A 20list 20of 20 20Key,5 20tables 20and 2For 20figures

Light AD, Obedin-Maliver J, Sevelius JM, Kerns JL. *Transgender men who experienced pregnancy after female-to-male gender transitioning*, 124 *Obstetrics Gynecol* 1120-1127 (Dec. 2014).

Klein, D.A., Paradise, S.L., and Goodwin, E.T. (2018). *Caring for Transgender and Gender-Diverse Persons: What Clinicians Should Know*. 98 *Am Fam Physician* 645-653 (2018).

Knudson G, De Sutter P. *Fertility options in transgender and gender diverse adolescents*, 96 *Acta Obstetrica et Gynecologica Scandinavia* 1269-1272 (July 2017).

Kuper, L.E. et al., *Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy*, 145 *Pediatrics* 1 (Apr. 2020).

Lilford, R.J. & J. Jackson, *Equipose and the Ethics of Randomization*, 88 *J. of the Royal Soc’y of Med.* 552 (Oct. 1995).

Martin S, Sandberg ES, Shumer DE: Criminalization of Gender-Affirming Care - Interfering with Essential Treatment for Transgender Children and Adolescents, 01/2021

McManus IC. The history and geography of human handedness. In: Language Lateralization and Psychosis. Edited by Sommer I, Kahn RS. Cambridge University Press. 2009: 37-58.

The National Board of Health and Welfare, Care of Children and Adolescents with Gender Dysphoria: Summary (2022), *available at* <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf>

National Institute for Health and Care Excellence (NICE), *Evidence Review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria* (2020), *available at* <https://cass.independent-review.uk/nice-evidence-reviews/>

Puhan, M.A., et al., *Discussing study limitations in reports of biomedical studies- the need for more transparency*, 10 Health and Quality of Life Outcomes 1 (2012).

Rafferty J, Yogman M, Baum R, et al. *Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents*. 142 Pediatrics (2018).

Rametti, G., Carrillo, B., Gomez-Gil, E., Junque, C., Segovia, S., Gomez, J., & Guillamon, A. (2011). White matter microstructure in female to male transsexuals before cross-sex hormonal treatment. A diffusion tensor imaging study. *Journal of psychiatric research*, 45(2), 199–204.

Reisner, S.L., et al., *Advancing Methods for U.S. Transgender Health Research*, 23 Current Opinion in Endocrinology & Diabetes and Obesity 198 (Apr. 2016).

Roselli C. E. (2018). Neurobiology of gender identity and sexual orientation. *Journal of neuroendocrinology*, 30(7), e12562.

Rosenthal SM, *Approach to the Patient: Transgender Youth: Endocrine Considerations*, J Clin Endocrinol Metab. 2014 Dec;99(12):4379-89.

Rothenberg, S., et al., *Oocyte Cryopreservation in a Transgender Male Adolescent*, 380 N Engl J Med 886-887 (2019).

Tordoff, D.M., et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5 JAMA Network Open (2022).

Turban, J.L., et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 Pediatrics 1 (2020).

Van der Loos MA, Hannema SE, Klink DT, et al. *Continuation of gender-affirming hormones in transgender people starting puberty suppression in adolescence: a cohort study in the Netherlands*. The Lancet Child & Adolescent Health. (2022), 6(12) 869-875.

van der Miesen, A.I.R., et al., *Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers*, 66 J. Adolescent Health 699 (June 2020).

Wiepjes, C.M. et al., *The Amsterdam cohort of gender dysphoria study (19 2 2015): trends in prevalence, treatment, and regrets*, 15 J. of Sexual Med. 582-590 (2018).

Wojniusz, S., Callens, N., Sütterlin, S., Andersson, S., De Schepper, J., Gies, I., et al. (2016). Cognitive, emotional, and psychosocial functioning of girls treated with pharmacological puberty blockage for idiopathic central precocious puberty. *Front. Psychol.* 7:1053. doi: 10.3389/fpsyg.2016.01053.

Zhang Q, Goodman M, Adams N, et al. Epidemiological considerations in transgender health: A systematic review with focus on higher quality data. *Int J Transgend Health.* 2020; 21(2): 125-137.