IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE, individually and on behalf of her minor daughter, SUSAN DOE, et al.,

Civil No. 4:23-cv-00114-RH-MAF

Plaintiffs,

v.

JOSEPH A. LADAPO, *in his official capacity as Florida's Surgeon General of the Florida Department of Health*, et al.,

Defendants.
_____/

PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION AND INCORPORATED MEMORANDUM OF LAW

Pursuant to Federal Rule of Civil Procedure 65, Plaintiffs move for an order preliminarily enjoining the enforcement of Fla. Admin. Code R. 64B8-9.019 and Fla. Admin. Code R. 64B15-14.014.

1. The Florida Board of Medicine adopted Rule 64B8-9.019, Fla. Admin. Code (effective March 16, 2023) and the Florida Board of Osteopathic Medicine adopted Rule 64B15-14.014, Fla. Admin. Code (effective March 28, 2023). These rules (the "Bans") bar doctors from providing established medical care to transgender adolescents.

2. Plaintiffs are Florida parents and their transgender children: Jane Doe and her daughter Susan Doe, Gloria Goe and her son Gavin Goe, and Linda Loe and her daughter Lisa Loe.

3. Each of the Minor Plaintiffs has been diagnosed with gender dysphoria and requires ongoing medical care, but because of the Bans, their parents are unable to obtain the care their children need. Susan Doe and Gavin Goe are about to enter puberty and will need puberty blocking medications, which Florida doctors are now banned from providing to transgender adolescents. Gavin Goe had a medical appointment to be assessed for puberty blocking medication, which was cancelled due to the Bans. Lisa Loe requires puberty blocking medication now; however, because of the Bans, no doctor in the state of Florida can provide the medical care she needs. Each of these Minor Plaintiffs will continue to suffer serious and irreparable harms if denied the medical care they need.

4. Plaintiffs are likely to succeed on the merits. The Bans violate the federal guarantee of due process by infringing upon parents' fundamental right to obtain established medical treatments for their children. In addition, the Bans violate the federal guarantee of equal protection by singling out transgender minors and prohibiting them from obtaining medically necessary treatment. The burden is on Defendants to justify these violations, but they cannot do so. The Bans' infringement on parental rights is not narrowly tailored to achieve a

compelling governmental interest. And the Bans' targeting of transgender adolescents is not substantially related to any important governmental interest.

5. Without the requested preliminary injunctive relief, the Bans will cause irreparable harm to the Parent Plaintiffs, who will be deprived of their fundamental right to make medical decisions for their children, notwithstanding that they are fit parents, and to the Minor Plaintiffs, who will suffer a cascade of mental and physical injuries. Plaintiffs have no adequate remedy at law.

6. The balance of equities and public interest tip sharply in favor of the Plaintiffs because the irreparable injuries far outweigh any burden on Defendants that might result from enjoining the Bans during the pendency of this case. The Bans prohibit care that is well-established and medically necessary for some transgender minors. In contrast, preventing enforcement of the Bans while this litigation proceeds poses no harm to Defendants and will preserve the status quo that has existed for many years before the Bans were adopted.

7. The Bans permit continued treatment of transgender minors who were already receiving these medications for the treatment of gender dysphoria before the Bans took effect. If these treatments are appropriate for transgender minors *already* receiving them, as their continued provision indicates, there is no justification for denying them to transgender minors who require them in the future even under the lowest level of review, much less under the heightened scrutiny

that applies here.

8. Plaintiffs request that the Court waive the bond requirement in Fed. R. Civ. P. 65(c). *See BellSouth Telecomm., Inc. v. MCIMetro Access Transmission Srvcs., LLC,* 425 F.3d 964, 971 (11th Cir. 2005). Public interest litigation is a recognized exception to the bond requirement, especially where, as here, the bond would injure Plaintiffs' constitutional rights and the relief sought would not pose a hardship to Defendants.

WHEREFORE, Plaintiffs respectfully request an order preliminarily enjoining Defendants from enforcing Rule 64B8-9.019, Fla. Admin. Code and Rule 64B15-14.014, Fla. Admin. Code (2023).

REQUEST FOR ARGUMENT

Pursuant to Local Rule 7.1(K), Plaintiffs respectfully request oral argument on this motion, estimating up to two hours for a non-evidentiary hearing.

MEMORANDUM OF LAW

I. Introduction

Plaintiffs are parents and their transgender children who challenge rules adopted by the Florida Boards of Medicine and Osteopathic Medicine (the "Medical Boards") that prevent doctors from providing medical treatments that have been available to transgender minors for decades.[1] These Bans deny established care for

[1] By separate motions, Parent and Minor Plaintiffs are requesting to proceed under pseudonyms.

transgender minors and infringe on parents' right to make medical decisions for their children, contrary to the Equal Protection and Due Process Clauses of the Fourteenth Amendment.

Absent an injunction, Plaintiffs will suffer immediate and irreparable harms. Because of the Bans, the Parent Plaintiffs are unable to obtain medically necessary and time-sensitive care for their transgender children, and the Minor Plaintiffs are unable to receive the medical care they need.

No monetary damages could compensate parents for the loss of their fundamental right to obtain established medical care for their children or for the pain of watching their children suffer due to the denial of such care. And no amount of money could compensate transgender adolescents for the physical and mental harms they will endure as a result of being denied the care they need.

II. Statement of Facts

A. The Bans Prevent Parent Plaintiffs from Making Important Medical Decisions for their Children's Health and Well-Being

1. Jane Doe and her Daughter Susan Doe

Susan Doe is an eleven-year-old girl who is transgender and resides with her mother Jane Doe, her father, and three siblings in St. Johns County. (*See* Declaration of Jane Doe ("Doe Decl.") ¶¶ 3, 6.) Jane is a special education teacher, and her husband is a Senior Officer in the United States Military. (*Id.* ¶¶ 4–5.) Susan knew she was a girl, and told her mother she was a girl, from a very young age. (*Id.* ¶¶ 7–

8.) When Susan was three years old, she began experiencing distress about wearing male clothing. (*Id.* ¶ 9.) Eventually, Jane sought advice from Susan's pediatrician, who advised Jane to support Susan rather than seek to force her to wear male clothing. (*Id.* ¶¶ 9–10.)

Despite Jane's fears and concerns about how Susan would be treated by others, she followed the pediatrician's advice. (*Id.* ¶ 11.) When Susan was allowed to dress as a girl and when those around her, including her family members peers, interacted with her as a girl, she became happier, more secure, and flourished. (*Id.* ¶ 12.) Because Susan has lived as a girl from a young age, she has gone through her entire school experience without anyone knowing she is transgender. (*Id.* ¶ 14.) If not enjoined, the Bans will change that by preventing Susan from accessing puberty blockers, the recommended treatment for her diagnosis of gender dysphoria, thus forcing her to go through male puberty inconsistent with her gender identity and the person she knows herself, and her friends and family know her, to be. (*Id.* ¶ 15.)

Susan will soon begin puberty. (*Id.* ¶ 18.) Her psychotherapist has concluded that she has no mental health issues or other concerns that would contraindicate puberty blocking medication when the time is appropriate and advised that Susan see a pediatric endocrinologist for continued assessment. (*Id.*) Susan is a patient at the University of Florida Health's Youth Gender Program, whose multidisciplinary treatment team has been monitoring Susan's course of treatment. (*Id.* ¶ 19.) Her

doctors have all agreed that it will likely be medically necessary for Susan to initiate puberty blockers as soon as she enters Tanner Stage 2, which could be any day now. (*Id.* ¶ 20.)

If the Bans remain in effect, Susan will not be able to begin puberty blocking medication when puberty begins. (*Id.* ¶ 20.) She will experience the effects of male puberty, which will cause her to develop physical traits inconsistent with her female gender identity, bringing back and exacerbating the distress that she experienced before she socially transitioned. (*Id.* ¶¶ 21–22.; Declaration of Dr. Roe ¶¶ 9–10.) The harm this will cause has been articulated by Susan as her biggest fear, and by Jane and her husband as their worst nightmare. (Doe Decl. ¶¶ 22, 26–29.)

2. Linda Loe and her Daughter Lisa Loe

Lisa Loe is an eleven-year-old girl who is transgender and has lived with her family in Miami-Dade County her entire life. (*See* Declaration of Linda Loe ("Doe Decl.") ¶¶ 2, 4.) Lisa's father owns a small law firm in Miami, where Lisa's mother, Linda Loe, works as the financial director. (*Id.* ¶ 3.) For years, Lisa's parents have worked hard to build a small business and a life in Florida. (*Id.*)

From an early age, Lisa gravitated toward interests and activities more typically associated with girls. (*Id.* ¶ 5.) When Lisa was nine years old, she told her parents that she is a girl. (*Id.* ¶ 6.) In 2022, Lisa was diagnosed with gender dysphoria. (*Id.* ¶ 7.) Her parents sought professional guidance from a psychologist,

who counseled them on how to support Lisa in beginning to live consistently with her female gender identity. (*Id.*) As Lisa's parents allowed her to do so, they saw Lisa's overall well-being improve greatly. (*Id*. ¶¶ 7–8.)

As Lisa is beginning puberty, her pediatrician referred her to a Miami-based pediatric endocrinologist who specializes in treatment for transgender adolescents. (*Id.* ¶ 10.) The endocrinologist confirmed that Lisa has gender dysphoria and has reached puberty. (*Id.* ¶¶ 9–10.) He counseled that Lisa would need puberty blockers administered within the next few months but informed Linda that he could not prescribe this medication because of the Bans. (*Id.* ¶ 11.) Lisa is anxious about her puberty progressing and her parents have encountered significant wait times for a new patient appointment at out-of-state clinics. (*Id.* ¶ 12.) If Lisa is unable to receive the medical care she needs, her health and well-being will suffer. (*Id.* ¶¶ 14–15.)

3. Gloria Goe and her Son Gavin Goe

Gavin Goe, the youngest of four children, is an eight-year-old boy who is transgender and lives with his family in Lee County. (*See* Declaration of Gloria Goe ("Goe Decl.") ¶¶ 3, 6, 8.) Gavin has known that he is a boy from a young age. (*Id.* ¶ 9.) He told his parents that he wanted to grow up to look like his father, consistently wanting a name, haircuts, and clothing typically associated with boys. (*Id.*) Gloria Goe, Gavin's mother, and her husband thought for some time that Gavin was simply a "tomboy," but over time, due to Gavin's distress from being treated as a girl, they

allowed Gavin to wear boys' clothes to school and use male pronouns. (*Id.* ¶¶ 10–12.) Eventually, Gloria and her husband allowed Gavin to use a male name. (*Id.* ¶ 12.)

In 2021, Gavin was diagnosed with gender dysphoria by a pediatrician. (*Id.* ¶ 16.) Last year, Gavin's pediatrician examined him and, considering his older sister began puberty at age nine, recommended that Gavin see a pediatric endocrinologist as puberty might be approaching. (*Id.*) Given Gavin's family history, the pediatrician advised the family to have Gavin assessed regularly for readiness for puberty blockers, as they need to be initiated soon after puberty starts; if not, he will lose the medical benefits they confer. (*Id.* ¶ 17)

Gloria made an appointment for Gavin at Johns Hopkins All Children's Hospital in St. Petersburg for March of 2023. (*Id.* ¶ 18.) On the morning of the scheduled appointment, Gloria learned that the clinic was no longer seeing new patients because the Florida Medical Boards had issued new rules banning the prescribing of medications to treat gender dysphoria for transgender youth. (*Id.* ¶ 20.) Gloria immediately sought out another clinic, hoping that Gavin could be assessed for treatment. (*Id.* ¶ 22.) The earliest appointment she could get for Gavin is September of 2023 at a clinic in New England, but she learned that the appointment is tentative pending a recommendation by that clinic's legal counsel regarding the risk associated with seeing a patient who lives in Florida. (*Id.*)

Gavin has positive relationships and development at school. (*Id.* ¶¶ 13–14.) While some school personnel know that he is transgender, Gavin does not want his classmates to know. (*Id.* ¶ 15.) If Gavin cannot receive puberty blockers, he will begin developing characteristics that will irreversibly identify him by his birth sex and predictably cause him serious psychological distress. (Goe Decl. Ex. A (Letter by Dr. Nicole M. Bruno).)

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

Gender identity is a person's internal sense of their sex. (*See e.g.*, Declaration of Dr. Daniel Shumer ("Shumer Decl.") ¶ 25); Declaration of Dr. Aron Janssen ("Janssen Decl. ¶ 17.) It is innate, has significant biological underpinnings, and cannot be changed. (Shumer Decl. ¶¶ 28–32; Janssen Decl. ¶ 19.) Every person has a gender identity. For most people, their gender identity aligns with their birth sex. For transgender people, however, that is not the case. (Shumer Decl. ¶ 25.)

Gender dysphoria is a serious medical condition that has been recognized and treated for decades. (Declaration of Dr. Brittany Bruggeman ("Bruggeman Decl.") ¶ 22; Shumer ¶ 35.) The diagnosis describes the clinical distress that a transgender person feels as a result of being made to live without any way to resolve the conflict between their birth sex and their gender identity. (Bruggeman Decl. ¶¶ 20; Shumer Decl. ¶ 35.) Gender dysphoria can be experienced by both youth and adults; it is rare, occurring in less than one percent of the population.

(Bruggeman Decl. ¶¶ 20, 69.) Left untreated, gender dysphoria may cause serious harms, including anxiety, depression, distress, self-harm, and suicidality. (Bruggeman Decl. ¶ 20; Shumer Decl. ¶ 39.)

The medical treatments for gender dysphoria are well-established (Bruggeman ¶ 21; Shumer Decl. ¶ 39.) When individuals with gender dysphoria receive appropriate medical care, they can thrive. (Bruggeman Decl. ¶ 49; Shumer Decl. ¶ 40.) The overall course of treatment that allows a transgender person to live consistent with their gender identity is called gender transition. (Bruggeman Decl. ¶ 24; Shumer Decl. ¶ 56.) For minors who experience gender dysphoria, being able to transition and receive appropriate medical care (often referred to as gender-affirming care) may be lifesaving. (Bruggeman Decl. ¶ 56.)

For more than four decades, medical organizations have developed standards of care for the treatment of gender dysphoria. (Bruggeman Decl. ¶¶ 22-23; Shumer Decl. ¶¶ 45–46.) The World Professional Association for Transgender Health ("WPATH") and the Endocrine Society have published standards of care and guidelines for treating gender dysphoria in children, adolescents, and adults, representing an expert consensus based on the best available science on transgender healthcare.[3] (Bruggeman Decl. ¶¶ 22, 51; Shumer Decl. ¶¶ 45–51.) Endorsed by the leading major medical organizations, the standards of care confirm that transition, including the use of puberty blocking medications and

hormone therapy when medically necessary, is a safe and effective treatment for gender dysphoria. (Bruggeman Decl. ¶¶ 22, 51-52; Shumer Decl. ¶¶ 52–53; Janssen Decl. ¶ 8.)

The specific components of a patient's transition and treatment plan are based on that individual's medical and mental health needs after comprehensive evaluation by a multidisciplinary team. (Bruggeman Decl. ¶¶ 30, 39; Shumer Decl. ¶ 37.) Qualified professionals manage these treatments. (Bruggeman Decl. ¶¶ 13, 30; Shumer Decl. ¶ 37.) The American Academy of Pediatrics has adopted this treatment protocol as safe and effective for the health and well-being of adolescents suffering from gender dysphoria. (Bruggeman Decl. ¶ 51; Shumer Decl. ¶ 52.)

Before a minor begins any treatment for gender dysphoria, health care providers undertake a rigorous informed consent process. (Bruggeman Decl. ¶¶ 30, 41, 45, 57; Shumer Decl. ¶ 65; Janssen Decl. ¶¶ 34–37, 41.) Once informed consent is obtained, there is extensive parent and patient education, counseling of parents and patients, and communication and coordination among physicians. (Bruggeman Decl. ¶ 30, 41; Janssen Decl. ¶ 41.)

The standards of care for the treatment of gender dysphoria in minors consist of social transition and related medical interventions that allow a young person to live consistently with their gender identity. (Bruggeman Decl. ¶¶ 22-29; Shumer Decl. ¶¶ 55–56; Janssen Decl. ¶ 25.) Social transition can include a person

using a name and pronouns that better align with their gender identity, wearing clothing and expressing themselves consistent with their gender identity, and amending their legal identification documents to reflect their gender identity. (Bruggeman Decl. ¶ 25; Shumer Decl. ¶ 45; Janssen Decl. ¶ 25.)

After the onset of puberty, minors diagnosed with gender dysphoria may be prescribed puberty blocking medications to prevent them from continuing to undergo endogenous puberty and developing permanent physical characteristics that conflict with their gender identity. (Bruggeman Decl. ¶¶ 26-27; Shumer Decl. ¶ 61.) Puberty blocking medications pause endogenous puberty at whatever stage it is when the treatment begins, limiting the influence of a person's endogenous hormones on their body. (Bruggeman Decl. ¶ 28; Shumer Decl. ¶ 62.) For example, a transgender girl on puberty blocking medication would not experience the physical changes caused by testosterone, including facial and body hair, male muscular development, an Adam's apple, or masculinized facial structures. (Bruggeman Decl. ¶¶ 26, 53, 55; Shumer Decl. ¶ 62.) Similarly, a transgender boy on puberty blocking medication would not experience breast development, menstruation, or widening of the hips. (Bruggeman Decl. ¶¶ 26, 53; Shumer Decl. ¶ 62.)

Treatment with puberty blocking medication is reversible; if a minor stops taking the medication, endogenous puberty resumes. (Bruggeman Decl. ¶ 28;

Shumer Decl. ¶¶ 63–64.) In addition to alleviating gender dysphoria and supporting a child's social transition, puberty blocking medications may eliminate the need for future surgical treatments to treat ongoing gender dysphoria as an adult, such as chest surgery, facial and body hair electrolysis, and feminizing facial surgeries. (Bruggeman Decl. ¶ 53; Shumer Decl. ¶ 65.) Banning puberty blocking medications for transgender adolescents may require them to undergo future surgeries as adults that they could otherwise avoid. (Bruggeman Decl. ¶ 53; Shumer Decl. ¶ 65.)

Later in adolescence, a transgender young person may be prescribed hormone therapy. (Bruggeman Decl. ¶ 29; Shumer Decl. ¶ 68.) Before such therapy begins, a mental health professional must: (1) confirm the persistence of gender dysphoria; (2) assess whether any coexisting psychological, medical, or social problems that could interfere with treatment have been addressed and whether the minor's situation and functioning are stable enough to start treatment; and (3) verify that the minor has an understanding of the consequences of the treatment. (Bruggeman Decl. ¶¶ 36-37; Shumer Decl. ¶ 70.) A pediatric endocrinologist or other medical doctor must also consent to and monitor the treatment plan. (Bruggeman Decl. ¶ 38; Shumer Decl. ¶¶ 56, 68.) With this treatment, a transgender adolescent would have the same typical levels of testosterone or estrogen as their non-transgender peer. (Shumer Decl. ¶ 71.)

C. Florida's Transgender Medical Bans

On June 2, 2022, Defendant State Surgeon General Ladapo sent a letter to Defendants Florida Board of Medicine and Board of Osteopathic Medicine to "establish a standard of care" for the treatment of gender dysphoria.[2] On July 28, 2022, the Florida Department of Health petitioned (hereinafter the "FDOH Petition") the Boards to initiate rulemaking to ban all medical treatment of gender dysphoria for minors.[3] On August 5, 2022, the Boards discussed Ladapo's June 2, 2022 letter and the FDOH Petition, voted to accept the FDOH Petition, and notified the public of the initiation of the rulemaking process.

At a joint meeting on October 28, 2022, the Medical Boards voted in support of proposed rule language that would ban puberty blockers and hormones, with an exception for nonsurgical treatment performed under an Institutional Review Board (IRB) approved clinical trial.[4] On November 4, 2022, and February 10, 2023, respectively, the Board of Medicine and the Board of Osteopathic Medicine voted to remove the exceptions from their proposed rules.

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[2] Letter from Surgeon General Ladapo to Florida Board of Medicine (June 2, 2022), https://perma.cc/DR2F-YKHG.

[3] Florida Department of Health's Petition to Initiate Rulemaking, *In re: Petition to Initiate Rulemaking Setting the Standard of Care for Treatment of Gender Dysphoria* (hereinafter "FDOH Petition") (July 28, 2022), available at https://perma.cc/5QHF-54BP.

[4] Meeting Minutes from the Florida Board of Medicine Board Meeting (Aug. 5, 2022), https://ww10.doh.state.fl.us/pub/medicine/Agenda_Info/Public_Information/Public_Minutes/2022/August/08052022_FB_Minutes.pdf .

The Florida Board of Medicine filed Rule No. 64B8-9.019 for adoption on February 24, 2023, and the Florida Board of Osteopathic Medicine filed Rule No. 64B15-14.014 for adoption on March 8, 2023. Both final rules contained the same language, which states:

> (1) The following therapies and procedures performed for the treatment of gender dysphoria in minors are prohibited.
>
> > (a) Sex reassignment surgeries, or any other surgical procedures, that alter primary or secondary sexual characteristics.
> > (b) Puberty blocking, hormone, and hormone antagonist therapies.
>
> (2) Minors being treated with puberty blocking, hormone, or hormone antagonist therapies prior to the effective date of this rule may continue with such therapies.

The Rules became effective on March 16, 2023, and March 28, 2023, respectively.

III. Argument

The purpose of a preliminary injunction is to preserve the status quo and thus prevent irreparable harm until the respective rights of the parties can be ascertained during a trial on the merits. *Powers v. Sec., Fla. Dep't of Corrections*, 691 F. App'x 581, 583 (11th Cir. 2017). To obtain a preliminary injunction, a movant must show: "(1) it has a substantial likelihood of success on the merits; (2) irreparable injury will be suffered unless the injunction issues; (3) the threatened injury to the movant outweighs whatever damage the proposed injunction may cause the opposing party; and (4) if issued, the injunction would not be adverse to

the public interest." *Jones v. Governor of Fla.*, 950 F.3d 795, 806 (11th Cir. 2020) (citing *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000) (en banc)). "[A]ll of the well-pleaded allegations of [the] complaint and uncontroverted affidavits filed in support of the motion for a preliminary injunction are taken as true." *Elrod v. Burns*, 427 U.S. 347, 350 n.1 (1976).

A. Plaintiffs Will Likely Succeed on the Merits of their Claims Because the Bans are Unconstitutional

Plaintiffs are substantially likely to succeed on the merits of their claims. The Bans infringe upon the Parent Plaintiffs' constitutional right to make medical decisions for their minor children and single out transgender minors for unequal treatment. As such, the Bans are subject to, and fail, heightened scrutiny. Rather than advancing any compelling or important governmental interests, they bar treatments that are safe, effective, and necessary for some transgender youth.

Federal courts have enjoined similar bans in other states, concluding that they infringe on parental autonomy and pose a serious risk to the health and well-being of transgender adolescents. "Parents, pediatricians, and psychologists—not the State or this Court—are best qualified to determine whether transitioning medications are in a child's best interest on a case-by-case basis." *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1146 (M.D. Ala. May 13, 2022), *appeal docketed*, No. 22-11707 (11th Cir. May 18, 2022); *see also Brandt v. Rutledge*, 551 F. Supp. 3d 882, 892 (E.D.Ark. 2021), *aff'd sub nom.*, 47 F.4th 661 (8th Cir. 2022) (finding that "Parent

Plaintiffs have a fundamental right to seek medical care for their children and, in conjunction with their adolescent child's consent and their doctor's recommendation, make a judgment that medical care is necessary."). The denial of this medical care will force Minor Plaintiffs to "to live with physical characteristics that do not conform to their gender identity, putting them at high risk of gender dysphoria and lifelong physical and emotional pain." *Brandt*, 551 F. Supp. 3d at 892; *see also Eknes-Tucker*, 603 F. Supp. 3d at 1150 ("without transitioning medications, Minor Plaintiffs will suffer severe medical harm, including anxiety, depression, eating disorders, substance abuse, self-harm, and suicidality").

1. The Bans Infringe on Parental Autonomy by Preventing Parents from Obtaining Established Medical Care for their Children

The Bans violate the fundamental right of the Parent Plaintiffs to obtain established medical care for their children. The Constitution protects parents' rights to make decisions "concerning the care, custody, and control of their children," based on a "presumption" that "fit parents act in the best interests of their children." *Troxel v. Granville*, 530 U.S. 57, 66, 68 (2000). This right is "perhaps the oldest of the fundamental liberty interests recognized by this Court." *Id.* at 65; *see also Parham v. J.R.*, 442 U.S. 584, 602 (1979) (collecting cases, including *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944), *and Pierce v. Soc'y of the Sisters of the Holy Names of Jesus & Mary,* 268 U.S. 510, 535 (1925)); *May v. Anderson*, 345 U.S. 528, 533 (1953) (recognizing that parental rights are "far more precious . . . than

property rights"). Any substantial infringement of this fundamental right is subject to strict scrutiny. *Lofton v. Sec'y of Dep't of Child. & Fam. Serv.*, 358 F.3d 804, 815 (11th Cir. 2004).

A parent's ability to seek and obtain established medical care to protect a child's health is a core aspect of this fundamental right. The Due Process Clause prohibits a state, "concerned for the medical needs of a child," from "willfully disregard[ing] the right of parents to generally make decisions concerning the treatment to be given to their children." *Bendiburg v. Dempsey*, 909 F.2d 463, 470 (11th Cir. 1990). "[P]arents have the right to decide free from unjustified governmental interference in matters concerning the growth, development and upbringing of their children." *Id.* (quoting *Arnold v. Bd. of Educ. of Escambia Cnty.*, 880 F.2d 305, 313 (11th Cir. 1989)).

The Bans negate this fundamental right by preventing the Parent Plaintiffs from obtaining care that has been available for decades, that is supported by our nation's leading medical associations, and that has been deemed medically necessary for their children by the children's treating providers.

None of Defendants' likely justifications for this intrusion on parental rights have merit, much less come close to meeting the strict scrutiny test. *See Eknes-Tucker*, 603 F. Supp. 3d at 1146 (holding Alabama's law criminalizing the provision of transition medications was "not narrowly tailored to achieve a

compelling government interest"); *Brandt*, 551 F. Supp. 3d at 893 (same).

2. The Bans Violate Equal Protection by Barring Medical Treatments for Transgender Adolescents

The Bans single out transgender adolescents to deny them medical care. As such, they discriminate based on transgender status and sex and may be upheld only if supported by an "exceedingly persuasive justification." *United States v. Virginia*, 518 U.S. 515, 531 (1996). Because the Bans cannot meet even rational basis review, much less this much more demanding test, Plaintiffs have a substantial likelihood of proving that the Bans violate the Equal Protection Clause.

a. The Bans are Subject to Heightened Scrutiny Under Well-Established Precedent

The Bans' discrimination against transgender people is apparent on their face. They prohibit "therapies and procedures performed for the treatment of gender dysphoria in minors," a condition experienced only by transgender minors. Rule Nos. 64B8-9.019, 64B15-14.014, Fla. Admin. Code (2023). Courts considering similar categorical exclusions have recognized that such measures facially discriminate based on a person's transgender status. *See e.g.*, *Brandt by & through Brandt v. Rutledge*, 47 F.4th 661, 669 (8th Cir. 2022); *Kadel v. Folwell*, No. 19-cv-272, 2022 WL 3226731, at *19 (M.D.N.C. Aug. 10, 2022); *Fain v. Crouch*, 2022 WL 3051015, at *8 (S.D. W.Va. Aug. 2, 2022); *Eknes-Tucker*, 603 F. Supp. 3d at 1146–48; *Fletcher v. Alaska*, 443 F. Supp. 3d 1024, 1027, 1030

(D. Alaska 2020); *Flack v. Wisconsin Dep't of Health Servs.*, 395 F. Supp. 3d 1001, 1019–22 (W.D. Wis. 2019); *Boyden v. Conlin*, 341 F. Supp. 3d 979, 1002–03 (W.D. Wis. 2018).

As these courts have recognized, it is not necessary that a law use the word "transgender" to facially discriminate against transgender people, just as a law criminalizing same-sex intimacy need not use the words "homosexuality" or "gay" to discriminate based on sexual orientation. Under settled law, a statute that classifies based on conduct or characteristics that either define or are closely correlated with a particular group facially discriminates against that group. *See, e.g.*,*Christian Legal Soc'y v. Martinez*, 561 U.S. 661, 689 (2010) (holding that a club's exclusion of people because they engaged in same-sex conduct was discrimination based on sexual orientation); *Lawrence v. Texas*, 539 U.S. 558, 583 (2003) (O'Connor, J., concurring) (stating that a law targeting conduct "closely correlated with being homosexual" is "directed toward gay persons as a class").

By discriminating against transgender people, the Bans also discriminate based on sex. Both the Supreme Court and the Eleventh Circuit have held that discrimination because a person is transgender is discrimination based on sex. *See Bostock v. Clayton Cty.*, 140 S. Ct. 1731, 1741 (2020) (holding that "it is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex"); *Glenn v. Brumby*,

663 F.3d 1312, 1316 (11th Cir. 2011) (holding that "discriminating against someone on the basis of his or her gender non-conformity constitutes sex-based discrimination under the Equal Protection Clause").

Under this controlling law, the Bans' targeting of transgender adolescents is subject to heightened scrutiny review under the Equal Protection Clause. *Brumby*, 663 F.3d at 1319 (holding that "discrimination on this basis is a form of sex-based discrimination that is subject to heightened scrutiny under the Equal Protection Clause").

In addition, even if considered as an independent classification, discrimination based on transgender status meets the criteria for suspect classification established in *Frontiero v. Richardson*, 411 U.S. 677, 686 (1973). As many courts across the country have held, transgender people have suffered a history of discrimination; being transgender is an immutable trait and one that is unrelated to a person's ability to participate in or contribute to society; and people who are transgender lack the political power to achieve full equality through the political process.[5] For these reasons, as well as because discrimination based on

[5] *See, e.g.*, *Whitaker v. Kenosha Unified Sch. Dist. No. 1*, 858 F. 3d 1034, 1051 (7th Cir. 2017); *Smith v. City of Salem*, 378 F.3d 566, 572 (6th Cir. 2004); *Toomey v. Arizona*, No. CV-19-00035-TUC-RM, 2019 WL 7172144, at *5 (D. Ariz. Dec. 23, 2019); *Stone v. Trump*, 400 F. Supp. 3d 317, 355 (D. Md. 2019); *F.V. v. Barron*, 286 F. Supp. 3d 1131, 1145 (D. Idaho 2018); *M.A.B. v. Bd. of Educ. of Talbot Cty.*, 286 F. Supp. 3d 704 (D. Md. 2018); *Board of Educ. of the Highland Local Sch. Dist. v. U.S. Dep't of Educ.*, 208 F. Supp. 3d 850, 874 (S.D. Ohio 2016); *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015); *Adkins v. City of New York*, 143 F. Supp.3d 134, 139 (S.D.N.Y. 2015).

transgender status is based on sex, policies that single out transgender people warrant heightened review.

Accordingly, Defendants "must show at least that the [challenged] classification serves important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives." *United States v. Virginia*, 518 U.S. 515, 516 (1996) (quotations omitted) (modifications in original). The justification for the classification must be "exceedingly persuasive," the burden of which "is demanding, and . . . rests entirely on the State." *Id*. Neither Defendants' asserted interests nor the alleged relationship between the interests and the discriminatory classification may "rely on overbroad generalizations." *Sessions v. Morales-Santana*, 137 S. Ct. 1678, 1692 (2017). Nor may Defendants "hypothesiz[e] or inven[t]" its interests "*post hoc* in response to litigation"—they must be the actual goals the policy was intended to advance at the time it was created. *Id.* at 1696–97 (quoting *Virginia*, 518 U.S. at 533).

b. Defendants Cannot Establish that their Asserted Justifications Serve Important Governmental Objectives or the that Bans are Substantially Related to the Achievement of those Objectives

The Bans prohibit parents from obtaining established care for their transgender children. Decades of evidence support the safety and efficacy of medications for treating gender dysphoria in adolescents. (Bruggeman Decl. ¶ 22;

Shumer Decl. ¶¶ 38–53; Janssen Decl. ¶¶ 29–30.) The Bans deprive transgender adolescents of medically necessary care and put them at risk of serious harms, including severe depression, anxiety, suicidality, and self-harm. As another federal district court recently held with respect to a similar ban, banning medical treatment for transgender adolescents fails heightened scrutiny and "would not even withstand rational basis scrutiny" because "[g]ender-affirming treatment is supported by medical evidence that has been subject to rigorous study," and "[e]very major expert medical association recognizes that gender-affirming care for transgender minors may be medically appropriate and necessary to improve the physical and mental health of transgender people"); *Brandt*, 551 F. Supp. 3d at 891–92; *see also Eknes-Tucker,* 603 F. Supp. 3d at 1138 (same); (Bruggeman Decl. ¶¶ 21–23, 50–52; Shumer Decl. ¶ 39; Janssen Decl. ¶ 28).

Defendants' justifications for the Bans have no basis in medical science and undermine, rather than advance, their purported goals of protecting children's health and safety. The Bans cannot survive even a cursory review, much less the demanding scrutiny required by this case.

i. The treatments are effective and well-established

Defendants are likely to claim that the use of puberty blocking medications and hormone therapy are ineffective to treat this condition, but that is factually inaccurate. In fact, decades of substantial scientific evidence show that these

treatments significantly improve mental health outcomes for transgender adolescents, including reducing rates of suicidal ideation and suicide attempts, which are significantly higher among transgender adolescent children when compared to their non-transgender peers. (Bruggeman Decl. ¶¶ 56, 61, 63; Shumer Decl. ¶¶ 38–53; Janssen Decl. ¶¶ 28–30.)

ii. The treatments are safe, and parents and patients are capable of assessing risks and benefits and providing informed consent and assent

Defendants cannot demonstrate that treatments for gender dysphoria are unsafe or that transgender adolescents and their parents are unable to assess their risks and benefits.

First, Defendants' likely assertion that the treatments are unsafe because they involve off-label use has no merit. "Off-label" refers to use of medication that has been approved by the Food and Drug Administration (FDA), but not for all conditions for which it may be effective.[6] Many established medical treatments involve off-label uses of FDA-approved medications. (Shumer Decl. ¶ 67.) Off-label use of medications for children is common and sometimes necessary, because an "overwhelming number of [FDA-approved] drugs" have no FDA-approved instructions for use in pediatric patients.[7]

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

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

> The purpose of off-label use is to benefit the individual patient. Practitioners use their professional judgment to determine these uses. As such, the term "off-label" does not imply an improper, illegal, contraindicated, or investigational use. Therapeutic decision-making must always rely on the best available evidence and the importance of the benefit for the individual patient.[8]

There is no legitimate reason, much less an important one as is required under heightened scrutiny review, to adopt a different rule for medications used to treat gender dysphoria in transgender patients.

Second, the medications used to treat gender dysphoria, including puberty blockers and hormones, are routinely used in the treatment of other medical conditions in youth. (Bruggeman Decl. ¶¶ 52, 54; Shumer Decl. ¶¶ 66–67.) Puberty blocking medication has been used for decades to treat a medical condition known as "precocious puberty." (Bruggeman Decl. ¶¶ 52, 54; Shumer Decl. ¶¶ 63, 66.) These medications are also used to treat verified disorder[s] of sexual developments, often referred to as intersex conditions. (Bruggeman Decl. ¶ 58.) Hormone therapy is often used to treat medical conditions experienced by adolescents, including painful menstruation, amenorrhea, and serious acne. (Bruggeman Decl. ¶ 58). While no medication can be shown to have zero risks,

[8] *Id.*

puberty blocking medication and hormones are considered very safe and well within acceptable risk factors for approved medication for minors. (Bruggeman Decl. ¶¶ 51–52, 54, 58, 60, 63; Shumer Decl. ¶¶ 74–86; Janssen Decl. ¶¶ 29–33.)

Moreover, contrary to any assertion that parents and patients are unable to provide informed consent to these treatments, any prescribed treatments, including puberty blocking medication and hormone therapy, are undertaken only after thorough assessment and discussion with parents and minor patients, and only after ensuring that all persons involved understand the need for treatment along with any attendant risks, just as in other medical situations where medication may be required to treat a condition. (Bruggeman Decl. ¶¶ 30, 36, 44-46, 54, 59; Shumer Decl. ¶¶ 37, 68, 70; Janssen Decl. ¶¶ 34–48.)

iii. Rather than protecting transgender adolescents, the Bans deprive Minor Plaintiffs of established medical care and leave them with no effective treatment for their gender dysphoria

In addition to lacking any basis in medical science, the Bans also fail heightened scrutiny because they deprive Minor Plaintiffs of established medical care to treat a serious medical condition. Under the standards of care, puberty blocking medication and hormone therapy are recognized as safe and effective treatments for adolescents with severe gender dysphoria. For many patients, there are no alternative medications or treatments that treat the condition. As a result, the Bans leave Minor Plaintiffs without medical treatment for their gender

dysphoria.

The irrationality—and harmfulness—of that result is underscored by the fact that the Bans permit minors who are already receiving these medications to continue doing so. If the banned medications are sufficiently safe and effective to permit youth already receiving them to continue treatment, there is no legitimate reason to bar them for youth with the same medical condition and whose medical need for them will arise in the future. This discrepancy defies logic and strongly suggests that the justifications are a post hoc justification for impermissible discrimination.

In sum, the burden is on Defendants to justify the Bans under heightened scrutiny, and they cannot do so. Defendants' policies lack even a rational justification, much less one that meets the much more demanding test applicable here. Rather than protecting the health of transgender adolescents, Defendants' categorical Bans harm the Minor Plaintiffs by depriving them of the individualized care and treatment to which they are entitled under established medical standards of care.

IV. The Bans are Causing Irreparable Harm to Plaintiffs

As an initial matter, it is well settled that the deprivation of constitutional rights, even without more, constitutes irreparable harm. *See Ne. Fla. Chapter of Ass'n of Gen. Contractors v. City of Jacksonville*, 896 F.2d 1283, 1285 (11th Cir.

1990). Here, the Bans deprive Plaintiffs of due process and equal protection, which in itself constitutes irreparable harm sufficient to warrant preliminary relief. The Bans violate parental rights. *See Eknes-Tucker*, 603 F. Supp. 3d at 1150 (finding parent plaintiffs demonstrated irreparable harm where act banning transition-related care for minors infringed on their fundamental right to parent their children); *Brandt*, 551 F. Supp. 3d at 892–93 (same). And the Bans deprive transgender adolescents of equal protection. *Eknes-Tucker*, 603 F. Supp. 3d at 1148; *Brandt*, 551 F. Supp. 3d at 892.

In addition, the Bans inflict other severe and irreparable harms. First, the Bans prevent the Parent Plaintiffs from obtaining established and time-sensitive medical care for their children. Like other parents, these Parent Plaintiffs want to be able to care for their children—to get their children the medical care that their treating physicians have recommended, and that they have witnessed for themselves, is essential to their children's ability to thrive. The Bans inflict serious, irreparable harm by barring the Parent Plaintiffs from acting in the best interests of their children, forcing them to sit by while their children suffer preventable harms.

Second, the Bans inflict irreparable harm by depriving the Minor Plaintiffs of necessary medical care for a serious medical condition. (Roe Decl. ¶¶ 9–10; Goe Decl. Ex. A). This denial will cause irreversible and harmful physical changes and

irreparable psychological harm, which may include anxiety, depression, severe psychological distress, and suicidality. Denial of medically necessary medical care is sufficient to show immediate and irreparable harm. *See, e.g.*, *Bowen v. City of New York*, 476 U.S. 467, 483–84 (1986) (finding denial of benefits caused irreparable injury by exposing plaintiffs to "severe medical setback[s]" or hospitalization); *Eknes-Tucker*, 603 F. Supp. 3d at 1150; *Gayle v. Meade*, 614 F. Supp. 3d 1175, 1206-07 (S.D. Fla. June 6, 2020) (holding that increased likelihood of serious illness constitutes an irreparable injury); *Flack v. Wis. Dep't of Health Servs.*, 331 F.R.D. 361, 373 (W.D. Wis. 2019) (denying coverage for medical treatment for gender dysphoria is irreparable harm).

Due to the nature of gender dysphoria and its time-sensitive treatments, every day that goes by in which Minor Plaintiffs are unable to obtain the medical care they need has a detrimental effect on both their immediate and long-term health and well-being.

As the district court found in *Brandt* when enjoining a similar Arkansas law, barring transgender youth from established medical care forces them to "undergo endogenous puberty," causing them to "live with physical characteristics that do not conform to their gender identity, putting them at high risk of gender dysphoria and lifelong physical and emotional pain." 551 F. Supp. 3d at 892; *see also Campbell v. Kallas*, No. 16-CV-261-JDP, 2020 WL 7230235, at *8 (W.D. Wis.

Dec. 8, 2020) (slip op.) (finding plaintiff demonstrated "irreparable injury" required for an injunction where plaintiff "continues to suffer from gender dysphoria, which causes her anguish and puts her at risk of self-harm or suicide").

Without the essential treatment Susan Doe needs, she will undergo a male puberty that conflicts with her female gender identity, causing her to suffer devastating and irreversible physical and psychological consequences. (Doe Decl. ¶¶ 21–22.) Susan Doe has expressed that this scenario is her "worst nightmare," and her mother, Jane Doe, can think of nothing more painful than watching her daughter go through the avoidable harms that will accrue due to the denial of this medically necessary treatment. (*Id.* ¶¶ 22, 26–29.)

The Bans are likewise harming Gavin Goe; they are preventing him from being assessed for medical care while approaching the age at which puberty will begin. (Goe Decl. Ex. A). Similarly, Lisa's doctor has determined that she needs puberty blocking medications, but her endocrinologist can no longer treat her in Florida because the Bans prohibit him from doing so. (Loe Decl. ¶ 11). For both Gavin and Lisa, going through a puberty that aligns with their birth sex rather than their gender identities will result in unwanted physical changes and psychological distress. These changes may cause Gavin and Lisa lifelong suffering and distress, in addition to putting them immediately at risk for the serous harms associated with untreated gender dysphoria. (Goe Decl. Ex. A; Loe Decl. ¶¶ 14–15.)

These harms are serious, irreparable, and potentially life-threatening. (Bruggeman Decl. ¶¶ 26, 50, 56, 61, 64–69; Shumer Decl. ¶ 39; Janssen Decl. ¶¶ 28; Roe Decl. ¶¶ 9–10; Goe Decl. Ex. A.)

V. The Imminent Threat of Harm to Plaintiffs Outweigh Any Damage to Defendants, Who Lack an Interest in Enforcing Unconstitutional Rules

The serious irreparable harms that Plaintiffs will experience if the Bans remain in effect outweigh any countervailing government interest. When "the nonmovant is the government, . . . the third and fourth requirements [for an injunction]—'damage to the opposing party' and 'public interest'—can be consolidated." *Otto v. City of Boca Raton*, 981 F.3d 854, 870 (11th Cir. 2020) (internal citations omitted); *Eknes-Tucker*, 603 F. Supp. 3d at 1150–51. In addition, there is no "legitimate interest in enforcing an unconstitutional [regulation]." *Otto*, 981 F.3d at 870.

Here, the balance of equities strongly favors an injunction. The medical care provided to transgender adolescents has been available for many years, and Defendants implicitly acknowledge that it is safe by permitting youth who were already receiving it to continue to do so. Under these circumstances, it is difficult to see any injury to Defendants or others that would be caused by delaying enforcement of the Bans while the case proceeds. Doing so would merely maintain the status quo before the Bans took effect.

In sharp contrast, the immediate harms to Plaintiffs if the bans are enforced are severe. The Parent Plaintiffs would be deprived of the "enduring American tradition" of "nurturing and caring for their children." *Eknes-Tucker*, 603 F. Supp. 3d at 1151 (citation omitted). The Minor Plaintiffs would experience a cascade of physical and psychological harms. Because these harms are so great, other courts have preliminarily enjoined similar bans. *Eknes-Tucker*, 603 F. Supp. 3d at 1150–51; *Brandt*, 551 F. Supp. 3d at 894.

VI. The Court Should Enjoin Enforcement of the Bans

"[I]n the case of a constitutional violation, injunctive relief must be tailored to fit the nature and extent" of the violation. *Georgia Advoc. Off. v. Jackson*, 4 F.4th 1200, 1209 (11th Cir. 2021), *vacated as moot*, 33 F.4th 1325 (11th Cir. 2022). "Once invoked, the scope of a district court's equitable powers . . . is broad, for breadth and flexibility are inherent in equitable remedies." *Brown v. Plata*, 563 U.S. 493, 538 (2011) (internal citations omitted). Unconstitutional agency regulations, like the transgender medical Bans, "are ordinarily vacated universally, not simply enjoined in application solely to the individual plaintiffs." *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Hum. Servs.*, 485 F. Supp. 3d 1, 64 (D.D.C. 2020).

An order enjoining the Bans on their face is necessary and proper. The Bans prohibit all doctors throughout Florida from prescribing the medications the Minor Plaintiffs need to remain healthy and thrive. The only remedy that will redress that

injury is an injunction that prevents Defendants from enforcing the Bans. Each of the movants needs to be able to find and secure medical treatment from doctors and healthcare providers to get the care they need. The Minor Plaintiffs cannot know with certainty the identity of all providers they may need to consult, nor is it feasible to issue an injunction that would apply only to specific patients or providers. In addition, the Bans are causing cascading effects including clinic closures and diminishment of available providers. All of those effects will continue and expand without a facial injunction against the Bans. As other courts considering similar bans have done, this Court should preliminarily enjoin Defendants from enforcing the Bans.

VII. Request for Relief from Requirement to Post Bond

Plaintiffs request an exemption from the requirements of Fed. R. Civ. P. 65(c). "[T]he amount of security required by [Rule 65(c)] is a matter within the discretion of the trial court . . . [and] the court may elect to require no security at all." *BellSouth Telecomm., Inc. v. MCIMetro Access Transmission Srvs., LLC,* 425 F.3d 964, 971 (11th Cir. 2005). Waiving the bond requirement is particularly appropriate in public interest litigation, where Plaintiffs allege the infringement of their constitutional rights. *See id*; *Washington v. DeBeaugrine*, 658 F. Supp. 2d 1332, 1339 (N.D. Fla. 2009); *Eknes-Tucker*, 2022 WL 1521889, at *13.

VIII. CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that this Court enjoin enforcement of the Bans while this lawsuit is pending.

Respectfully submitted this 24th day of April, 2023.

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CERTIFICATION OF WORD LIMIT

Pursuant to Local Rule 7.1(F), undersigned counsel certifies that, according to Microsoft Word, the word-processing system used to prepare this Motion and Memorandum, there are 668 total words contained within the Motion, and there are 7,209 words contained within the Memorandum of Law.

/s/ Simone Chriss
Simone Chriss

CERTIFICATE OF SATISFACTION OF ATTORNEY-CONFERENCE REQUIREMENT

Pursuant to Local Rule 7.1(B), Counsel for Plaintiffs requested to meet and confer with Defendants' Counsel on April 20, 2023. On April 24, 2023, Counsel for Defendants indicated that Defendants oppose the relief sought.

CERTIFICATE OF SERVICE

I hereby certify that, on April 24, 2023, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system. Counsel for Defendants stated that they would accept service via email. I certify that I served by email the foregoing on the following non-CM/ECF participant:

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/s/ Simone Chriss
Simone Chriss

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE, individually and on behalf of her minor daughter, SUSAN DOE, et al., *Plaintiffs*, v. JOSEPH A. LADAPO, M.D., *in his official capacity as Florida's Surgeon General of the Florida Department of Health,* et al., *Defendants*.	Case No. 4:23-cv-00114-RH-MAF

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

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

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

2. I am a plaintiff in this Action and I am the parent and next friend of my minor child, Susan Doe, who is also a Plaintiff in this action.

[1] Because of concerns about my child's privacy and safety, I have filed a motion with this Court seeking to proceed in this case under a pseudonym. *See ECF 21, Motion to Proceed Pseudonymously*. In addition, contemporaneous with signing this declaration, I have signed with my legal name a separate copy of this declaration. My attorneys have a copy of that separate declaration.

3. I am a Florida resident. I live in St. Johns County with my four children and my husband.

4. I was born and raised in New York. I am a special education teacher licensed to work in K-12, and I have a Masters of Education in special education, with two highly qualified endorsements in math and language arts (ELA). I have taught both high school and middle school for many years in various states.

5. My husband is a Senior Officer in the U.S. Military. He is a Lieutenant Commander in the U.S. Navy, in line to become Commander, and is current on assignment at the Pentagon. My family was stationed in Florida due to my husband's job.

6. My daughter, Susan, who is also a Plaintiff in this action, is an eleven-year-old girl who is transgender.

7. Susan began stating that she is a girl from an early age and has consistently done so since that time.

8. Even before Susan could speak, she gravitated toward her sister's dolls and would not play with any of the "traditional boy's toys" we purchased for her. She was always genuinely confused as to why these things were being offered to her. Susan would constantly ask me why I was dressing her in boys' clothes. She repeatedly told me that she was a girl and developed extreme anxiety and distress

about wearing "boys' clothes." This finally escalated to the point that she would rip her clothes off on the way to daycare until she was in only a diaper.

9. Around the age of three, after she began expressing significant distress about her clothing, I brought Susan to the pediatrician and explained what was happening, looking for an answer to help my unhappy and anxious child.

10. The pediatrician advised me "not to fight it" and to allow her to dress the way she felt comfortable and play with the toys she naturally gravitated to. He advised me "it will be either pass or it won't, but either way it will be okay."

11. This was difficult at first, as I was fearful about how the world would receive and treat my child. But we could not sit by and allow her to continue suffering based on our notions of what clothes are "normal" or "typical" for little girls and little boys.

12. Once we began allowing Susan to wear dresses, including to school (after discussions with school leadership and her teachers), she was like a different child. She was happy, glowing, secure, and we began to see all of the little things that made Susan exactly who she was. She began to flourish in ways that took my breath away once she was able to live her truth and express herself.

13. I came from a strict Irish Catholic family, so initially it was difficult for my family to understand what was happening. It took a year or two for my family to

understand that this was not a phase, but rather this is who Susan is. She is lucky to have a network of family who support her and love her unconditionally.

14. Because Susan was able to socially transition so early, she has gone through school from pre-K to her current grade, without anyone ever knowing that her sex assigned at birth was male. She has had the privilege that so many trans youth are denied, the privilege of navigating through the world without having to explain who she is, or be subjected to discrimination or hatred because of her mere existence.

15. That will all change, however, if Susan is forced to go through endogenous puberty because of the Florida Medical Boards' new rules. This would not only be physically, emotionally, and psychologically devastating for Susan, but it would also "out" her to others without her consent.

16. Susan has been legally recognized as female by the state and federal government. Her government-issued identification documents, including her birth certificate and official education records, reflect her legal gender marker: female.

17. We have done everything right, following the Standards of Care and the guidance of numerous doctors with clinical expertise in the treatment of gender dysphoria. Susan's gender dysphoria diagnosis has been confirmed by doctors in Nevada, in Virginia, in Florida, and at the Pentagon, including the doctor who is responsible for the transgender health program for the entire United States military. We have always sought out the expertise of the most qualified medical providers we

could find in the country, and we have followed their guidance throughout Susan's transition.

18. Susan is right on the cusp of puberty. However, well before she was approaching the start of puberty, and prior to discussing puberty blocking medications with a pediatric endocrinologist, we took Susan to see a psychotherapist who specializes in transgender youth. The psychotherapist assessed Susan and concluded there were no mental health issues or any other concerns that would deem puberty blocking medications inappropriate for Susan. She said puberty blocking medications would likely be medically necessary when the time was right, and expressed that Susan should meet with a pediatric endocrinologist to determine next steps.

19. We then made an appointment to get established as patients at the University of Florida ("UF") Health Youth Gender Program. Though our appointments require approximately 4 hours of driving round trip, we felt it was so important to establish care with a multidisciplinary treatment team with expertise in the treatment of gender dysphoria in minors. The pediatric endocrinologists at the Youth Gender Program have been monitoring Susan's prepubertal development and Tanner Stage for the past year and a half. Susan's pediatric endocrinologist has explained all the details about beginning puberty blocking medication when the time is right and this medication becomes medically necessary, including significant

counseling on the effects, risks, and the science supporting the use of these medications for youth experiencing gender dysphoria.

20. Susan's medical providers, including her pediatrician, pediatric endocrinologist, and medical provider on base, have all concluded that pursuant to the authoritative standards of care, it will be medically necessary for Susan to begin puberty blocking medications as soon as she enters Tanner Stage 2, which could be any day now. But the Board rules prohibit my child from receiving the treatment that has been recommended as medically necessary by her treating providers. The rules rob her of the right to access evidence-based medical care that has been deemed necessary to treat her gender dysphoria by the experts overseeing her medical care.

21. Denying my child medications to treat gender dysphoria would be cruel. Susan is a happy, kind, thoughtful, loving child. She is a straight A student, a girl scout, a talented gymnast, a visual artist, the captain of the safety patrol team at her school, on the principal's honor roll, part of the choir group, and a leader among her friend groups. She is loved by teachers, neighbors, and friends. She is sassy, smart, compassionate, intuitive, and lives her life in a way that gives more than she takes.

22. Forcing her to go through endogenous male puberty would be life changing and devastating for Susan's physical, emotional, and psychological

wellbeing. In fact, she has stated to me many times -- and it breaks my heart -- that her biggest fear is having to "turn into a boy."

23. The Board rules substitute the judgment of a group of providers who have never met nor treated my child, for the judgment of my child's actual medical providers who are experts on her medical needs and experts in the treatment of gender dysphoria in minors. They strip me, the parent of Susan, of the right to determine the best course of medical care for my own daughter.

24. The Board rules put me and my husband in an impossible position, as we do not have the luxury of simply moving to another state where our parental rights to determine the medical care for our own child will not be trampled upon, where the rights of parents are truly respected and upheld. I never in my wildest dreams imagined the state would put me and my family in this predicament. As Susan's mother, I know what is best for her and I want only to follow the advice of my child's medical providers. We are not in Florida by choice, we are in Florida because this is where we were stationed by the United States military. This new rule treats military families stationed in Florida differently than those stationed elsewhere. The Board of Medicine's decision to discriminate against transgender children and strip their parents of their rights makes Florida an unsafe state for all military families with transgender children.

25. The Department of Defense has been incredibly supportive of our family and of our transgender daughter throughout this entire process. The military doctors have been huge advocates for her, consistently advocating on her behalf for the best treatment that could be provided to her, and they have treated Susan with dignity and respect on every level. The Department has helped ensure that she has had access to medically necessary gender-affirming healthcare, and the Tri-Care health insurance plan provided by the Department of Defense to military families affirmatively covers all gender-affirming care. However, because of this new rule, members of the United States Military who are stationed in Florida will be subjected to worse treatment and have less rights than military families stationed elsewhere.

26. The Florida Board of Medicine's adoption of the new rule has thrown me, and my entire family, into a massive state of stress, anxiety, uncertainty, and panic. We worry daily about what will happen to our healthy, happy, thriving daughter if she is forced to go through what she has described as her worst nightmare, become something she isn't. We cannot even allow ourselves to think about the toll it would take on her emotionally, mentally, physically, psychologically, socially, academically, and beyond. My husband and I lay awake at night absolutely riddled with fear about how this perfect little girl's life is going to be torn apart. In addition to the impacts on Susan's body and mind, we worry about how she will be treated by friends, neighbors, and strangers once she is

forcibly outed to everyone in her life who have only ever known Susan as female. "Torture" is the only word I've identified to adequately describe the feelings of terror a parent experiences in a situation like this.

27. From the start of the Board of Medicine's rulemaking process back in June of 2022, I have felt a near constant sense of dread. There isn't a single moment of the day where the thought of not being able to protect my daughter isn't on my mind. It has interfered with my husband's work performance, as he is so worried about our child not receiving the medical care she needs. He has spent hours and hours trying to determine solutions to all the "what if's" about our future and our ability to protect our daughter in this state.

28. After the final rule was filed with the Department of State, removing all doubt that Florida doctors would soon be prohibited from providing evidence-based medical treatment for children in Florida like Susan, we flew Susan to Washington D.C. to meet with the chief pediatric endocrinologist at the Walter Reed medical facility. The doctor confirmed that Susan had not entered Tanner Stage 2 and, pursuant to the WPATH Standards of Care was not yet ready to start puberty blocking treatment. We spent over a thousand dollars on the trip, Susan had to miss school, my husband had to make special arrangements to get the time off, and the outcome was not what we were hoping for, but we had to be sure that our daughter wasn't ready to start puberty blocking treatment before the rule went into effect.

29. The actions by the Florida Board of Medicine threaten the health, safety, and wellbeing of my daughter and many other transgender children in the state of Florida. No parent should be forced to sit by, powerless, stripped of their parental rights to care for their child, while they watch their child experience unnecessary trauma and distress, and undergo changes that will profoundly harm them.

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

Executed this 19th day of April 2023.

Respectfully Submitted,

DocuSigned by:
Jane Doe
B68AE8FBFEFD4D8...

Jane Doe

Exhibit A

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE, individually and on behalf of her minor daughter, SUSAN DOE, et al., *Plaintiffs*, v. JOSEPH A. LADAPO, M.D., *in his official capacity as Florida's Surgeon General of the Florida Department of Health,* et al., *Defendants*.	Civil No. 4:23-cv-00114-RH-MAF

DECLARATION OF DR. RACHEL ROE, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Rachel Roe, M.D.[1], hereby declare and state as follows:

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

[1] I have filed a motion with this Court seeking to proceed in this case under a pseudonym. In addition, contemporaneous with signing this declaration, I have signed with my legal name a separate copy of this declaration. Counsel for Plaintiffs have a copy of that separate declaration.

2. I am a pediatrician and I am licensed to practice medicine in Florida by the Florida Board of Medicine.

3. Plaintiff known as Susan Doe in this matter (the "patient"), has been a patient under the care of my practice since November, 2021. She is eleven years old.

4. In my professional opinion, the patient meets the clinical criteria for a diagnosis of gender dysphoria. The patient was diagnosed with gender dysphoria by her pediatrician, and the diagnosis has been confirmed by myself and another physician in my practice.

5. For patients with gender dysphoria, the onset of puberty can cause or exacerbate distress arising from the incongruence between their sex assigned at birth and their gender identity. For some adolescent patients, their gender dysphoria can cause them to experience depression, anxiety, and suicidal ideation when left untreated.

6. When an adolescent reaches puberty, they may require puberty blocking medication (commonly referred to as puberty blockers) to treat their gender dysphoria, depending on the individualized and unique needs of the patient. Puberty blockers can delay the onset of puberty and prevent the development of secondary sex characteristics that are not aligned with the patient's gender identity if the intervention is timely. Puberty blockers should not be initiated before puberty has

begun, but the treatment must be initiated promptly after the patient enters Tanner stage 2 or the treatment may be ineffective.

7. Physicians with expertise in pediatric endocrinology and the treatment of gender dysphoria in adolescents, in close coordination with the parents of the adolescent patient, are best situated to assess an individual patient's need for puberty blockers. When timely administered, puberty blockers can alleviate the symptoms of gender dysphoria.

8. During her appointment with me in November of 2022, after examining the patient and considering her family history, it was my opinion that the onset of puberty was likely imminent. In my professional opinion, the patient has an imminent need for treatment because she has a limited window of time to get the medical benefit of puberty blockers.

9. In my professional opinion, the patient is at serious risk of irreparable harm if she cannot be prescribed puberty blockers by her treating physicians upon the onset of puberty, which could be any day now. My understanding is that the new rules adopted by the Florida Board of Medicine and the Florida Board of Osteopathic Medicine prohibit me and the patient's other treating physicians from prescribing puberty blockers to any transgender adolescent, regardless of medical necessity or harms of withholding such treatment.

10. The patient may have already begun puberty based on my last medical assessment, and every day the patient is prevented from receiving treatment after having a physician determine her readiness for puberty blockers, subjects her to potential irreparable physical, mental, and emotional harm.

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

Executed this 20th day of April 2023.

Respectfully Submitted,

Rachel Roe MD

Dr. Rachel Roe, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE, individually and on behalf of her minor daughter, SUSAN DOE, et al., *Plaintiffs*, v. JOSEPH A. LADAPO, M.D., *in his official capacity as Florida's Surgeon General of the Florida Department of Health,* et al., *Defendants*.	Case No. 4:23-cv-00114-RH-MAF

DECLARATION OF LINDA LOE IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Linda Loe,[1] hereby declare and state as follows:

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

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

2. I am a plaintiff in this Action and I am the parent and next friend of my minor child, Lisa, who is also a Plaintiff in this action. I am a Florida resident and live in Miami-Dade County with my husband of fifteen years and our two children.

3. My family has always considered Miami to be our home. I moved to Miami when I was two years old and have lived in the area ever since. My husband was born in Brooklyn, NY but has resided in Miami-Dade County since he began college. He is a worker's compensation attorney who runs a small law firm representing injured workers across the state of Florida. I work alongside him as the finance director of his firm. We have worked hard to build our small business over the course of 18 years, and are proud of the legal services we provide to our community.

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

5. Although Lisa has a male birth sex, she has always gravitated toward interests and activities that are more stereotypically associated with girls. At around age five, I noticed that Lisa was drawn to the girl's toy section of our local department store. As she grew older, she increasingly preferred toys and other products traditionally marketed to girls, and she would often tell me that she wished that they made Barbies for boys. All of her closest friends were girls.

6. In February of 2022, when she was nine years old, Lisa told me that she was a girl. I was not surprised by the news, and neither was my husband. We come from a loving and accepting family, so we were thrilled that Lisa felt comfortable articulating these feelings. At the time, we were naïve to the stigma and marginalization that transgender children face. If I knew then what I know now, I would have been terrified for my daughter.

7. In March of 2022, Lisa became depressed as a result of her gender dysphoria. We sought the care of a psychologist who assisted us in supporting Lisa to begin to live consistent with her female gender identity. We began to allow Lisa to wear clothing that was more feminine and grow her hair out long, which helped to alleviate some of Lisa's depressive symptoms.

8. When Lisa began living in accordance with her gender identity, I witnessed a wonderful change in her overall wellbeing and happiness. This came as no surprise to my husband and me, but we were not prepared for the stigmatization that was in store for her. While she was comfortable at home, teachers and fellow classmates continued to refer to her as a boy rather than as a girl. Because the class was often categorized by gender, Lisa was consistently forced to sit with the boys rather than the girls. I would see the light drain out of Lisa's eyes every time she told me about these painful experiences.

9. Lisa's gender dysphoria was greatly exacerbated by her experiences at school. It evolved to the point where she developed both motor and verbal tics due to the stress and anxiety that the school environment had imposed upon her. She began to fail her math exams, despite knowing the material, because being treated like a boy in the classroom exacerbated her dysphoria and distress. Because we were concerned about the toll this was taking on Lisa both academically and socially, we withdrew her from the school she had attended since kindergarten and enrolled her in a new school that we hoped would be supportive and committed to her inclusion and equal treatment as a transgender girl.

10. With Lisa on the cusp of puberty, our pediatrician referred us to a Miami-based pediatric endocrinologist who specializes in the treatment of gender dysphoria in transgender youth. In his clinical evaluation of Lisa in the fall of 2022, our endocrinologist confirmed her diagnosis of gender dysphoria and set a follow-up appointment to assess her pubertal stage and readiness to initiate puberty blocking medication.

11. At her follow-up appointment in March 2023, Lisa's endocrinologist confirmed that she has reached puberty and will need puberty blockers prescribed within the next few months. However, we were heartbroken to hear that our provider was no longer permitted to prescribe Lisa the puberty blocking medication we know to be medically necessary for her. Due to the Florida Board of Medicine's new rules,

our doctor advised that we would have to travel out of state for Lisa to receive this necessary medical care.

12. Lisa is incredibly anxious as her puberty progresses, and we feel as if it is a race against the clock to find care elsewhere. We have heard that there are significant wait times for new patients at out-of-state clinics.

13. I believe our trusted medical provider, and all leading medical authorities, when they say that this treatment is medically necessary to enable Lisa and other transgender children like her to thrive. However, the Florida Medical Boards' rules prevent me from making the informed and evidence-based medical decisions for my daughter and from accessing the care she needs in Florida. As her parent, I feel like my hands are tied.

14. The level of stigma that these rules impose upon us is also hard to bear. The rule makes me feel as if I am seeking "black market" medicine for my child in forcing us to travel hundreds of miles away from our community to receive the care Lisa needs to survive and thrive. We have considered leaving Florida, but it would involve abandoning our family and friends, family business, and the only home we have ever known.

15. Lisa is a profoundly intelligent and happy-go-lucky kid, but I have seen the devastating toll that her gender dysphoria has taken on her mental health. Lisa felt so relieved when we enrolled her in a new school where no one would misgender

her. I worry that if Lisa does not get the medical care she needs, her health and well-being will suffer. It pains me so much to think of the impact that these rules will have on her as she is trapped within a developing body that she does not recognize as her own.

16. As a parent, it is my duty to protect Lisa from harm and ensure that she has everything she needs to live a healthy life. But I feel powerless in the face of this rule, and unable to protect her from the harm and marginalization that it imposes upon us.

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

Executed this 19th day of April 2023.

Respectfully Submitted,

Linda Loe

Linda Loe

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE, individually and on behalf of her minor daughter, SUSAN DOE, et al., *Plaintiffs*, v. JOSEPH A. LADAPO, M.D., *in his official capacity as Florida's Surgeon General of the Florida Department of Health,* et al., *Defendants*.	Civil No. 4:23-cv-00114-RH-MAF

DECLARATION OF GLORIA GOE IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Gloria Goe,[1] hereby declare and state as follows:

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

2. I am a plaintiff in this Action and I am the parent and next friend of my minor child, Gavin Goe, who is also a Plaintiff in this action.

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

3. I am a resident of Florida. I live in Lee County with my four children and my husband.

4. I was born and raised in the Midwest, where we all lived until 2021. I have extensive experience in the insurance sales industry, and my husband works as a supervisor at a large business services company.

5. My husband and I have known each other since grade school and we have been married since 2007. We have four children.

6. Two years ago, my husband and I decided to move from the Midwest to Florida in pursuit of our dream to raise our children in a warm location near the ocean.

7. My youngest son, Gavin, who is also a Plaintiff in this action, is an eight-year-old boy who is transgender. He is in second grade.

8. Gavin has known that he was a boy from a very young age. He consistently wanted short haircuts and masculine clothing, and also asked why he could not have a boy's name. He often told us he would grow up to "look handsome like daddy."

9. For some time, my husband and I thought Gavin was a "tomboy" who simply did not enjoy feminine things. Incrementally, we came to understand and accept his desire to appear less feminine.

10. Gavin, who has always been incredibly self-assured and often seems wise beyond his years, began asking searching questions several years ago that reflected a sense of distress, including, "Mommy, why does nobody believe I am a boy?" He also sought out photographs of boys to show us how he wanted to look. Eventually, we came to understand that Gavin is transgender.

11. While we experienced a sense of grief that our child was no longer our daughter, we also wanted Gavin to thrive and we learned, with the support of other parents, how essential it is that we support him and love him exactly as he is. During his pre-K and Kindergarten years of school in the Midwest, we began allowing him to wear boys' clothes to school and to use male pronouns and, eventually, a male name.

12. Gavin is a great student. He performs above his grade level in reading, math, and other subjects. He enjoys school and his teachers enjoy teaching him and having him in the classroom.

13. Gavin is very spirited and social. He makes friends easily and he participates in all activities available to him. He seeks out any opportunity to experience joy with other people.

14. While his school principal, his counselor, and his teacher know that Gavin is transgender, his classmates do not know. Gavin does not want his peers to

know that he is transgender. If Gavin were to develop secondary sex characteristics associated with his birth sex, his classmates would know he is transgender.

15. Gavin was diagnosed with gender dysphoria in 2021 by a pediatrician. In 2022, he saw another pediatrician who assessed him to determine if he was approaching the onset of puberty. After examining him and considering that his older sister had begun puberty at age nine, the pediatrician recommended that he see a pediatric endocrinologist. (Attached as Exhibit A, Letter by Dr. Nicole M. Bruno).

16. Even though he was still young, the pediatrician said, given his family history, it was important that Gavin be assessed regularly for puberty blockers because they need to be initiated very soon after puberty starts. If he does not receive them at that time, he will likely be deprived of the medical benefits they confer.

17. Based on that referral, I made an appointment for Gavin with Dr. Suzanne Jackman at Johns Hopkins All Children's Hospital in St. Petersburg, Florida for March of 2023.

18. I believe, based on what I know about my son, and based on my discussions with his pediatrician, that the onset of endogenous puberty will likely be extremely distressing for Gavin. As puberty progresses, if he cannot receive puberty blockers, not only will he begin developing characteristics that will irreversibly identify him by his birth sex, his peers will learn that he is transgender. Puberty

blocking medication could prevent these irreparable harms, but *only* if he receives them early after the onset of puberty.

19. The morning of the scheduled appointment, before driving two hours to the clinic, I called to confirm the appointment. At that time, I was told that the clinic was no longer seeing new patients because the Florida Boards of Medicine and Osteopathic Medicine had issued new rules governing medical care for transgender youth.

20. This information was shocking to my husband and me. We had not known it was possible that doctors would be prevented from assessing and prescribing medical treatments our children may need.

21. Immediately, I sought out another clinic in the hope that Gavin could be assessed for treatment. The earliest appointment I could get for Gavin is September of 2023 at a clinic in New England. But I have been told that the appointment is tentative pending a recommendation by that clinic's legal counsel regarding the risk associated with seeing a patient who lives in Florida.

22. My husband and I are concerned that our son will begin puberty and will be unable to get the treatment he needs for his gender dysphoria to prevent the development of secondary sex characteristics associated with his birth sex.

23. The actions by the Florida Boards of Medicine and Osteopathic Medicine threaten the health, safety, and wellbeing of my son and other transgender children in the state of Florida.

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

Executed this 13 th day of April 2023.

Respectfully Submitted,

Gloria Goe

Gloria Goe

Exhibit A

April 17th, 2023
To: [redacted]
RE: [redacted]

Island Coast
PEDIATRICS

Martin J. McKenna, MD
Jose V. Padilla-Lopez, MD
Thomas L. Seitz, MD
Wilfred K. Lee, MD
Nicole M. Bruno, DO
Luke J. McKenna, MD
Teresa F. Stevens, MD
Marcia E. Antigua-Lee, MD
Ashton M. Rety, DO
Vincent S. Munizza, MS, PA-C
Terry L. Warren, PA-C
Tara J. Heroux, APRN

Holly Velez, RN, BSM
Practice Administrator
Sandra Rosalez
Administrative Manager
Megan Hansen
Clinical Manager
Elizabeth Bentley
Financial Cycle Manager
Ashlee Cruz
H.R.Manager

Business Office
632 Del Prado Blvd. N, Suite 301
Cape Coral, FL 33909
Office: (239) 768-2111
Fax: 239-482-4404
Email:
Pxrequests@islandcoastpeds.com
Website: ICPeds.com

I am writing on behalf of the above mentioned patient of Island Coast Pediatrics. I am licensed to practice medicine in Florida by the Florida Board of Medicine. I am a physician working in a medical practice known as Island Coast Pediatrics. I see patients at all of our office locations.

[redacted] also known as Gavin Goe, has been a patient under the care of my practice for two years. He is eight years old.

In my professional opinion, the patient meets the clinical criteria for a diagnosis of gender dysphoria which another member of my practice diagnosed the patient with in 2021. For patients with gender dysphoria, the onset of puberty can cause or exacerbate distress arising from the incongruence between their birth sex and their gender identity. That distress may require medical treatment by a specialist in endocrinology.

Among the treatments available to minor patients experiencing gender dysphoria, puberty suppressing medication (commonly known as puberty blockers) can delay the onset of puberty if intervention is timely. Puberty blockers for a transgender patient should not be initiated before puberty has begun. Puberty blockers may be ineffective; however, if treatment is initiated too late in the patient's pubertal development, puberty blockers cannot reverse pubertal changes a patient has already experienced.

Specialists in pediatric endocrinology are best situated to assess an individual patient's need for puberty blockers and to determine the correct timing for administration of medication. If timely administered, puberty blockers can alleviate the symptoms of gender dysphoria. In 2022, after examining the patient and considering his family history, it was my opinion that the patient would be approaching the onset of puberty now or within the next few years. In my professional opinion, the patient has a need for assessment and treatment from a pediatric endocrinologist because he has a limited window of time to get the full medical benefit of puberty blockers.

In my professional opinion, it was appropriate to refer the patient to a specialist in pediatric endocrinology. On or about June 24, 2022, I referred the patient to a pediatric endocrinologist, Dr. Suzanne Jackman, at Johns Hopkins All Children's Hospital in St. Petersburg, Florida. It is my understanding based on my referral; the patient scheduled an appointment with a pediatric endocrinologist for March of 2023 and it was cancelled by the clinic because of new rules issued by the Florida Board of Medicine and the Florida Board of Osteopathic Medicine, which prohibit doctors from treating transgender patients with puberty blockers.

Respectfully Submitted,

Nicole M. Bruno, D.O.

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE, individually and on behalf of her minor daughter, SUSAN DOE, et al.,

Civil No. 4:23-cv-00114-RH-MAF

Plaintiffs,

v.

JOSEPH A. LADAPO, *in his official capacity as Florida's Surgeon General of the Florida Department of Health*, et al.,

Defendants.
_____/

EXPERT DECLARATION OF DANIEL SHUMER, M.D.

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

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

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

I. BACKGROUND AND QUALIFICATIONS

A. Qualifications

3. I am a Pediatric Endocrinologist, Associate Professor of Pediatrics, and the Clinical Director of the Child and Adolescent Gender Clinic at Mott Children's

Hospital at Michigan Medicine. I am also the Medical Director of the Comprehensive Gender Services Program at Michigan Medicine, University of Michigan.

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

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

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

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

8. I have published extensively on the topic of gender identity in pediatrics

and the treatment of gender dysphoria, as well as reviewed the peer-reviewed literature concerning medical treatments for gender dysphoria, the current standards of care for the treatment of gender dysphoria, and research articles on a variety of topics with a focus on mental health in transgender adolescents.

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

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

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

12. The Child and Adolescent Gender Services Clinic has treated over 600 patients since its founding. The clinic provides comprehensive assessment, and when appropriate, treatment with pubertal suppression and hormonal therapies, to patients diagnosed with gender dysphoria. I have personally evaluated and treated over 400 patients with gender dysphoria. The majority of the patients receiving care range between 10 and 21 years old. Most patients attending clinic live in Michigan or Ohio. As the Clinical Director, I oversee the clinical practice, which currently includes 4 physicians (including 1 psychiatrist), 1 nurse practitioner, 2 social workers, 1 research coordinator, as well as nursing and administrative staff. I also actively conduct research related to transgender medicine, gender dysphoria treatment, and mental health concerns specific to transgender youth.

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

I lead Michigan Medicine's broader efforts related to transgender services. CGSP is comprised of providers from across the health system including pediatric care, adult hormone provision, gynecologic services, adult surgical services, speech/language therapy, mental health services, and primary care. I run monthly meetings with representatives from these areas to help coordinate communication between Departments. I coordinate strategic planning aimed to improve care within the health system related to our transgender population. I also serve as the medical representative for CGSP in discussions with health system administrators and outside entities.

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

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

B. Prior Testimony

16. In the past four years, I have been retained as an expert and provided testimony at trial or by deposition in the following cases: *Roe et al v. Utah High School Activities Association et al* (Third District Court in and for Salt Lake County, UT); and

Menefee v. City of Huntsville Bd. of Educ., No. 5:18-cv-01481 (N.D. Ala.). I also provided expert witness testimony on behalf of a parent in a custody dispute involving a transgender child in the following case: *In the Interest of Younger*, No. DF-15-09887 (Dallas County, Texas). I have also been retained as an expert witness in *Boe v. Marshall*, No. 2:22-cv-00184-LCB-SRW (M.D. Ala.) and *Dekker v. Weida*, No. 4:22-cv-00325-RH-MAF (N.D. Fla.).

C. Compensation

17. I am being compensated at an hourly rate for the actual time that I devote to this case, at the rate of $325 per hour for any review of records, preparation of reports, declarations, and deposition and trial testimony. My compensation does not depend on the outcome of this litigation, the opinions that I express, or the testimony that I provide.

D. Bases for Opinions

18. In preparing this declaration, I reviewed the text of the Standards of Practice for the Treatment of Gender Dysphoria in Minors issued by the Florida Board of Medicine and Florida Board of Osteopathic Medicine in 2023.

19. I have also reviewed the materials listed in the bibliography attached as **Exhibit B** to this report, as well as the materials listed within my curriculum vitae, which is attached as **Exhibit A**. The sources cited therein include authoritative, scientific peer-reviewed publications. They include the documents specifically cited as

supportive examples in particular sections of this report. I may rely on these materials as additional support for my opinions.

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

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

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

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

II. EXPERT OPINIONS

A. MEDICAL AND SCIENTIFIC BACKGROUND ON SEX AND GENDER IDENTITY

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

25. *Gender identity* is the medical term for a person's internal, innate sense

of belonging to a particular sex. Everyone has a gender identity. Diversity of gender identity and incongruence between assigned sex at birth and gender identity are naturally occurring sources of human biological diversity (IOM, 2011). The term *transgender* refers to individuals whose gender identity does not align with their sex assigned at birth (Shumer, et al., 2013).

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

27. A person's understanding of their gender identity may evolve over time in the natural course of their life, however, attempts to "cure" transgender individuals by forcing their gender identity into alignment with their birth sex has been found to be both harmful and ineffective. In one study, transgender adults who recall previous attempts from healthcare professionals to alter their gender identity reported an increase

in lifetime suicide attempts and higher rates of severe psychological distress in the present (Turban, et al., 2020a). In another study, exposure to these types of attempts were found to increase the likelihood that a transgender adolescent will attempt suicide by 55% and more than double the risk for running away from home (Campbell, et al., 2002). Those practices have been denounced as unethical by all major professional associations of medical and mental health professionals, such as the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, and the American Psychological Association, among others (Fish, et al., 2022).

28. Scientific research and medical literature across disciplines demonstrates that gender identity, like other components of sex, has a strong biological foundation. For example, there are numerous studies detailing the similarities in the brain structures of transgender and non-transgender people with the same gender identity (Luders, et al., 2009; Rametti, et al., 2011; Berglund, et al., 2008; Savic, et al., 2011). In one such study, the volume of the bed nucleus of the *stria terminalis* (a collection of cells in the central brain) in transgender women was equivalent to the volume found in non-transgender women (Chung, et al., 2002).

29. There are also studies highlighting the genetic components of gender identity. Twin studies are a helpful way to understand genetic influences on human diversity. Identical twins share the same DNA, while fraternal twins share roughly

50% of the same DNA, however both types of twins share the same environment. Therefore, studies comparing differences between identical and fraternal twin pairs can help isolate the genetic contribution of human characteristics. Twin studies have shown that if an identical twin is transgender, the other twin is much more likely to be transgender compared to fraternal twins, a finding which points to genetic underpinnings to gender identity development (Heylens, et al., 2012).

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

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

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

B. RATIONALE FOR MEDICAL TREATMENT OF GENDER DYSPHORIA IN ADOLECENTS

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

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

access hormonal interventions.

C. ASSESSMENT OF GENDER DYSPHORIA IN CHILDREN AND ADOLESCENTS

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

36. The World Health Organization's International Classification of Diseases (ICD), the diagnostic and coding compendia for mental health and medical professionals, codifies Gender Incongruence as the diagnosis resulting from the incongruity between one's gender identity and birth sex. The Gender Incongruence diagnosis is part of a new "Conditions related to sexual health" chapter in the ICD-11, which is the most recent iteration of the ICD published in 2019 (Costa, et al., 2015;

WHO, 2019). This reflects evidence that transgender and gender diverse identities are not conditions of mental ill health and classifying them as such can cause enormous stigma.

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

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

ADOLESCENTS

38. The goal of any intervention for gender dysphoria is to reduce dysphoria, improve functioning, and prevent the harms caused by untreated gender dysphoria.

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

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

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

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

involving medications may be appropriate.

43. For pre-pubertal children with gender dysphoria, treatments may include supportive therapy, encouraging support from loved ones, and assisting the young person through elements of a social transition. Social transition may include adopting a new name and pronouns, appearance, and clothing, and correcting identity documents.

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

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

46. WPATH has been recognized as the standard-setting organization for the treatment of gender dysphoria since its founding in 1979. The most recent WPATH

Standards of Care (SOC 8) were published in 2022 and represent expert consensus for clinicians related to medical care for transgender people, based on the best available science and clinical experience (Coleman, et al., 2022).

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

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

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

50. In addition, the Endocrine Society is a 100-year-old global membership

organization representing professionals in the field of adult and pediatric endocrinology. In 2017, the Endocrine Society published clinical practice guidelines on treatment recommendations for the medical management of gender dysphoria, in collaboration with Pediatric Endocrine Society, the European Societies for Endocrinology and Pediatric Endocrinology, and WPATH, among others (Hembree, et al, 2017).

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

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

52. The AAP is the preeminent professional body of pediatricians in the United States, with over 67,000 members. The AAP endorses a commitment to the optimal physical, mental, and social health and well-being for youth. The 2018 policy statement titled *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents* further lends support to the treatment

options outlined in the WPATH Standards of Care and the Endocrine Society's Clinical Practice Guidelines (Rafferty, et al., 2018).

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

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

E. TREATMENT PROTOCOLS FOR GENDER DYSPHORIA IN CHILDREN AND ADOLESCENTS

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

young people who reported high levels of family rejection are significantly more likely to have attempted suicide, to report high levels of depression, to use illegal drugs, and to be at high risk for HIV and sexually transmitted diseases compared with transgender young people who report no or low levels of rejection by family due to their identity (Ryan, et al., 2010).

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

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

58. Gender exploration in childhood is expected and healthy. The majority of prepubertal children exploring their gender do not develop gender dysphoria and are

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

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

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

adulthood (de Vries, et al., 2012).

i. Treatment with puberty-delaying medications

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

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

Hembree, et al., 2017; Rosenthal, 2014).

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

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

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

66. As an experienced pediatric endocrinologist, I treat patients with these same medications for both precocious puberty and gender dysphoria and in both cases

the side effects are comparable and easily managed. And for both patient populations the risks are greatly outweighed by the benefits of treatment.

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

ii. Treatment with hormone therapy

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

69. These hormone therapies are used to treat gender dysphoria in adolescents to facilitate development of sex-specific physical changes congruent with their gender identity. For example, a transgender boy prescribed testosterone will develop a lower voice as well as facial and body hair, while a transgender girl prescribed estrogen will experience breast growth, female fat distribution, and softer skin.

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

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

starting hormonal care after completing puberty, discussion of egg or sperm preservation prior to starting treatment is recommended.

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

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

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

74. GnRHa, prescribed for delaying puberty in transgender adolescents, is both a safe and effective treatment. Patients under consideration for treatment are working within a multidisciplinary team of providers all dedicated to making

informed and appropriate decisions with the patient and family in the best interest of the adolescent. Physicians providing this intervention are trained and qualified in gender identity concerns and childhood growth and development and are participating in this care out of a desire to improve the health and wellness of transgender youth and prevent negative outcomes such as depression and suicide.

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

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

who have been treated with GnRHa over decades. Symptoms of this side effect (headache, vomiting, visual changes) are reviewed with families and if they occur the medication is discontinued.

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

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

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

be balanced with the risk of withholding treatment.

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

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

82. Hormone therapy (testosterone or estrogen) is prescribed to older adolescents with gender dysphoria. As is the case with GnRHa, the need for hormone therapy is not unique to transgender adolescents. Patients with conditions such as delayed puberty, hypogonadism, Turner Syndrome, Klinefelter Syndrome, agonism, premature ovarian failure, and disorders of sex development all require treatment with

these hormones, often starting in adolescence and continuing lifelong. Without testosterone or estrogen treatment, these patients would be unable to progress through puberty normally, which would have serious medical and social consequences. Whether used in adolescents to treat gender dysphoria, or to treat any of these other conditions, testosterone and estrogen are prescribed with a goal to raise the testosterone or estrogen level into the normal male or female range for the patient's age. Careful monitoring of blood levels and clinical progress are required. Side effects are rare, but most often related to overtreatment, which can be minimized with this monitoring. Additionally, side effects are considered, discussed, and easily managed in all individuals needing hormone therapy regardless of the diagnosis necessitating these medications.

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

84. Treatment of gender dysphoria with testosterone or estrogen is highly beneficial for both short-term and long-term psychological functioning of adolescents with gender dysphoria and withholding treatment from those who need it is harmful (e.g., Achille, et al., 2020; Allen, et al., 2019; Chen, et al., 2023; de Lara, et al., 2020;

de Vries, et al., 2014; Grannis, et al., 2021; Green, et al., 2022; Kaltiala, et al., 2020; Kuper, et al., 2020). To highlight examples, Green et al. (2022) describe that gender-affirming hormone therapy is correlated with reduced rates of depression and suicidality among transgender adolescents. Turban et al. (2022) documented that access to gender-affirming hormone therapy in adolescence is associated with favorable mental health outcomes in adulthood, when compared to individuals who desired but could not access hormonal interventions.

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

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

G. HARMS ASSOCIATED WITH PROHIBITING AND DISCONTINUING TREATMENT

87. Prohibition of gender-affirming care for adolescents is likely to have devastating consequences. I am concerned such a prohibition might lead to a

staggering increase in mental health problems including suicidality for transgender children and adolescents in Florida. One study which highlights my concern is a study of over 21,000 patients who report ever desiring gender-affirming hormone care. When comparing those who were able to access this care to those desiring but never accessing care, those able to access care had lower odds of suicidality within the past year. In addition, those individuals where were able to access care in adolescence had lower odds of suicidality compared to those waiting to access until adulthood (Turban, et al., 2022).

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

III. CONCLUSION

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

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

91. Lack of access to these treatments will result in worse outcomes for

countless youth in Florida. Furthermore, banning coverage for evidence-based treatment for gender dysphoria sends a message that transgender youth are not valid and should be stigmatized.

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

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

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

Executed this 7th day of April 2023.

Daniel Shumer, M.D.

Exhibit A

Curriculum Vitae

Daniel Shumer, MD MPH

Clinical Associate Professor in Pediatrics - Endocrinology

Email: dshumer@umich.edu

EDUCATION AND TRAINING

Education

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

Postdoctoral Training

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

CERTIFICATION AND LICENSURE

Certification

10/2011-Present	American Board of Pediatrics, General

Licensure

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

09/2015-Present Michigan, DEA Registration

09/2015-Present Michigan, Controlled Substance

WORK EXPERIENCE

Academic Appointment

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

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

Administrative Appointment

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

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

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

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

Clinical Appointments

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

Private Practice

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

RESEARCH INTERESTS

- Gender dysphoria
- Prader Willi Syndrome

CLINICAL INTERESTS

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

GRANTS

Past Grants

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

HONORS AND AWARDS

National

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

Institutional

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

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

TEACHING MENTORSHIP

Resident

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

Clinical Fellow

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

Medical Student

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

TEACHING ACTIVITY

Regional

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

Institutional

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

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

MEMBERSHIPS IN PROFESSIONAL SOCIETIES

2012 - Present	Pediatric Endocrine Society

COMMITTEE SERVICE

National

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

Regional

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

Institutional

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

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

VOLUNTEER SERVICE

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

SCHOLARLY ACTIVITIES

PRESENTATIONS

Extramural Invited Presentation Speaker

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

Other

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25. Gender Identity, Universalist Unitarian Church of East Liberty, 04/2021, Virtual due to COVID

26. Unconscious Bias, Ascension St. John Hospital, 05/2021, Virtual due to COVID

PUBLICATIONS/SCHOLARSHIP

Peer-Reviewed Articles

1. Vengalil N, Shumer D, Wang F: Developing an LGBT curriculum and evaluating its impact on dermatology residents, *Int J Dermatol*.61: 99-102, 01/2022. PM34416015

Chapters

1. Shumer: Coma. In Schwartz MW6, Lippincott Williams & Wilkins, Philadelphia, PA, (2012)

2. Shumer, Spack: Medical Treatment of the Adolescent Transgender Patient. In Đorđević M; Monstrey SJ; Salgado CJ Eds. CRC Press/Taylor & Francis, (2016)

3. Kinnear HA, **Shumer DE**: Duration of Pubertal Suppression and Initiation of Gender-Affirming Hormone Treatment in Youth. In FinlaysonElsevier, (2018)

4. Araya, **Shumer DE**: Endocrinology of Transgender Care – Children and Adolescents. In Poretsky; Hembree Ed. Springer, (2019)

Non-Peer Reviewed Articles

1. Shumer D: The Effect of Race and Gender Labels in the Induction of Traits, *Northwestern Journal of Race and Gender Criticism*.NA01/2014

2. Shumer D: A Tribute to Medical Stereotypes, *The Pharos, Journal of the Alpha Omega Alpha Medical Society*.Summer07/2017

3. Mohnach L, Mazzola S, Shumer D, Berman DR: Prenatal diagnosis of 17-hydroxylase/17,20-lyase deficiency (17OHD) in a case of 46,XY sex discordance and low maternal serum estriol, *Case Reports in Perinatal Medicine*.8(1)01/2018

4. Mohnach L, Mazzola S, Shumer D, Berman DR: Prenatal Diagnosis of 17-hydroxylase/17,20-lyase deficiency (17OHD) in a case of 46,XY sex discordance and low maternal serum estriol, *Case Reports in Perinatal Medicine*.8(1)12/2018

5. Kim C, Harrall KK, Glueck DH, **Shumer DE**, Dabelea D: Childhood adiposity and adolescent sex steroids in the EPOCH (Exploring Perinatal Outcomes among Children) study, *Clin Endocrinol (Oxf)*.91(4): 525-533, 01/2019. PM31278867

6. Araya A, Shumer D, Warwick R, Selkie E: 37. “I’ve Been Happily Dating For 5 Years” - Romantic and Sexual Health, Experience and Expectations in Transgender Youth, *Journal of Adolescent Health*.66(2): s20, 02/2020

7. Araya A, Shumer D, Warwick R, Selkie E: 73. "I think sex is different for everybody" - Sexual Experiences and Expectations in Transgender Youth, *Journal of Pediatric and Adolescent Gynecology*.33(2): 209-210, 04/2020

8. Araya AC, Warwick R, Shumer D, Selkie E, Rath T, Ibrahim M, Srinivasan A: Romantic Health in Transgender Adolescents, *Pediatrics*.Pediatrics01/2021

9. Martin S, Sandberg ES, **Shumer DE**: Criminalization of Gender-Affirming Care - Interfering with Essential Treatment for Transgender Children and

Adolescents, *New England Journal of Medicine*.385(7): 579-581, 08/2021. PM34010528

Editorial Comment

1. **Shumer DE**, Harris LH, Opipari VP: The Effect of Lesbian, Gay, Bisexual, and Transgender-Related Legislation on Children, 01/2016. PM27575000

2. **Shumer DE**: Health Disparities Facing Transgender and Gender Nonconforming Youth Are Not Inevitable, 01/2018. PM29437859

3. Martin S, Sandberg ES, Shumer DE: Criminalization of Gender-Affirming Care - Interfering with Essential Treatment for Transgender Children and Adolescents, 01/2021

Erratum

1. Tishelman AC, Kaufman R, Edwards-Leeper L, Mandel FH, **Shumer DE**, Spack NP: Correction to Serving Transgender Youth: Challenges, Dilemmas, and Clinical Examples, [Professional Psychology: Research and Practice, 46(1), (2015) 37-45], *Professional Psychology: Research and Practice*.46(4): 249, 08/2015

Journal Articles

1. **Shumer DE**, Thaker V, Taylor GA, Wassner AJ: Severe hypercalcaemia due to subcutaneous fat necrosis: Presentation, management and complications, *Archives of Disease in Childhood: Fetal and Neonatal Edition*.99(5)01/2014. PM24907163

2. Tishelman AC, Kaufman R, Edwards-Leeper L, Mandel FH, **Shumer DE**, Spack NP: Serving transgender youth: Challenges, dilemmas, and clinical examples, *Professional Psychology: Research and Practice*.46(1): 37-45, 02/2015. PM26807001

3. Reisner SL, Vetters R, Leclerc M, Zaslow S, Wolfrum S, **Shumer DE**, Mimiaga MJ: Mental health of transgender youth in care at an adolescent Urban community health center: A matched retrospective cohort study, *Journal of Adolescent Health*.56(3): 274-279, 03/2015. PM25577670

4. **Shumer DE**, Tishelman AC: The Role of Assent in the Treatment of Transgender Adolescents, *International Journal of Transgenderism*.16(2): 97-102, 04/2015. PM27175107

5. **Shumer DE**, Roberts AL, Reisner SL, Lyall K, Austin SB: Brief Report: Autistic Traits in Mothers and Children Associated with Child's Gender Nonconformity, *Journal of Autism and Developmental Disorders*.45(5): 1489-1494, 05/2015. PM25358249

6. Tishelman AC, Kaufman R, Edwards-Leeper L, Mandel FH, **Shumer DE**, Spack NP: Reply to comment on "serving transgender youth: Challenges, dilemmas, and clinical examples" by Tishelman et al. (2015), *Professional Psychology: Research and Practice*.46(4): 307, 08/2015. PM26858509

7. **Shumer DE**, Reisner SL, Edwards-Leeper L, Tishelman A: Evaluation of Asperger Syndrome in Youth Presenting to a Gender Dysphoria Clinic, *LGBT Health*.3(5): 387-390, 10/2016. PM26651183

8. Tishelman AC, **Shumer DE**, Nahata L: Disorders of sex development: Pediatric psychology and the genital exam, *Journal of Pediatric Psychology*.42(5): 530-543, 01/2017. PM27098964

9. Edwards-Leeper L, **Shumer DE**, Feldman HA, Lash BR, Tishelman AC: Psychological profile of the first sample of transgender youth presenting for medical intervention in a U.S. pediatric gender center, *Psychology of Sexual Orientation and Gender Diversity*.4(3): 374-382, 01/2017

10. **Shumer DE**, Abrha A, Feldman HA, Carswell J: Overrepresentation of adopted adolescents at a hospital-based gender dysphoria clinic, *Transgender Health*.2(1): 76-79, 07/2017. PM28861549

11. Strang JF, Meagher H, Kenworthy L, de Vries AL C, 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, Kuschner 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, *Journal of Clinical Child and Adolescent Psychology*.47(1): 105-115, 01/2018. PM27775428

12. Selkie E, Adkins V, Masters E, Bajpai A, **Shumer DE**: Transgender Adolescents' Uses of Social Media for Social Support, *Journal of Adolescent Health*.66(3): 275-280, 03/2020. PM31690534

13. Warwick RM, **Shumer DE**: Gender-affirming multidisciplinary care for transgender and non-binary children and adolescents, *Children's Health Care*.01/2021

14. Araya AC, Warwick R, **Shumer DE**, Selkie E: Romantic relationships in transgender adolescents: A qualitative study, *Pediatrics*.147(2)02/2021. PM33468600

15. Warwick RM, Araya AC, **Shumer DE**, Selkie EM: Transgender Youths' Sexual Health and Education: A Qualitative Analysis, *Journal of Pediatric and Adolescent Gynecology*.35(2): 138-146, 04/2022. PM34619356

Letters

1. Strang JF, Janssen A, Tishelman A, Leibowitz SF, Kenworthy L, McGuire JK, Edwards-Leeper L, Mazefsky CA, Rofey D, Bascom J, Caplan R, Gomez-Lobo V, Berg D, Zaks Z, Wallace GL, Wimms H, Pine-Twaddell E, **Shumer DE**, Register-Brown K, Sadikova E, Anthony LG: Revisiting the Link: Evidence of the Rates of Autism in Studies of Gender Diverse Individuals, *Journal of the American Academy of Child and Adolescent Psychiatry*.57(11): 885-887, 11/2018. PM30392631

Letters to editor

1. **Shumer DE**: Doctor as environmental steward, 01/2009. PM19364173

Notes

1. **Shumer DE**, Mehringer J, Braverman L, Dauber A: Acquired hypothyroidism in an infant related to excessive maternal iodine intake: Food for thought, *Endocrine Practice*.19(4): 729-731, 07/2013. PM23512394

Podcasts

1. Gaggino L, Shumer WG D: Pediatric Meltdown: Caring for Transgender Youth with Compassion: What Pediatricians Must Know, 01/2020

Reviews

1. **Shumer DE**, Spack NP: Current management of gender identity disorder in childhood and adolescence: Guidelines, barriers and areas of controversy, *Current Opinion in Endocrinology, Diabetes and Obesity*.20(1): 69-73, 02/2013. PM23221495

2. Guss C, **Shumer DE**, Katz-Wise SL: Transgender and gender nonconforming adolescent care: Psychosocial and medical considerations, *Current Opinion in Pediatrics*.27(4): 421-426, 08/2015. PM26087416

3. **Shumer DE**, Nokoff NJ, Spack NP: Advances in the Care of Transgender Children and Adolescents, *Advances in Pediatrics*.63(1): 79-102, 08/2016. PM27426896

Short Surveys

1. **Shumer DE**, Spack NP: Transgender medicine-long-term outcomes from 'the Dutch model', *Nature Reviews Urology*.12(1): 12-13, 01/2015. PM25403246

Abstracts/Posters

1. Shumer D, Kinnear H, McLain K, Morgan H: Development of a Transgender Medicine Elective for 4th Year Medical Students, National Transgender Health Summitt, Oakland, CA, 2017

2. Shumer D: Overrepresentation of Adopted Children in a Hospital Based Gender Program, World Professional Association of Transgender Health Biennial International Symposium, Amsterdam, The Netherlands, 2016

3. Shumer D: Mental Health Presentation of Transgender Youth Seeking Medical Intervention, World Professional Association of Transgender Health Biennial International Symposium, Amsterdam, The Netherlands, 2016

4. Adkins V, Masters E, Shumer D, Selkie E: Exploring Transgender Adolescents' Use of Social Media for Support and Health Information Seeking (Poster Presentation), Pediatric Research Symposium, Ann Arbor, MI, 2017

Exhibit B

Bibliography

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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 Med.* 2023 Jan 19;388(3):240-250.

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IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE, individually and on behalf of her minor daughter, SUSAN DOE, et al.,

Civil No. 4:23-cv-00114-RH-MAF

Plaintiffs,

v.

JOSEPH A. LADAPO, *in his official capacity as Florida's Surgeon General of the Florida Department of Health*, et al.,

Defendants.
_____/

EXPERT DECLARATION OF ARON JANSSEN, M.D.

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

Background and Qualifications

2. The information provided regarding my professional background, experiences, publications, and presentations are detailed in my curriculum vitae. A

true and correct copy of my CV is attached as Exhibit A.

3. I received my medical degree from the University of Colorado School of Medicine. I completed my residency in psychiatry and a fellowship in child and adolescent psychiatry at New York University Langone Medical Center.

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

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

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

7. I am a contributing author to the Child and Adult Mental Health chapters of the Eighth Version of the World Professional Association for

Transgender Health's (WPATH) *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8* (hereafter, "WPATH SOC").

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

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

10. I am an Associate Editor for the journal *Transgender Health*, and an

Ad Hoc Reviewer for the journal *LGBT Health*. Each of these publications is a peer-reviewed medical journal.

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

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

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

provide.

14. In the previous four years, I was retained as an expert witness by the plaintiffs and deposed in *B.P.J. v. West Virginia State Board of Education* et al., No. 2:21-cv-00316 (S.D.W.V.), and *L.E. v. Lee* et al, No. 3.21-cv-00835 (M.D. Tenn). I have also been retained as an expert witness in *Boe v. Marshall*, No. 2:22-cv-00184-LCB-SRW (M.D. Ala.) and *Dekker v. Weida*, No. 4:22-cv-00325-RH-MAF (N.D. Fla.).

Basis for Opinions

15. My opinions contained in this declaration are based on: (1) my clinical experience as a psychiatrist treating transgender patients, including adolescents and young adults; (2) my knowledge of the peer-reviewed research, including my own, regarding the treatment of gender dysphoria, which reflects the clinical advancements in the field of transgender health; (3) my work as a contributing author of the WPATH SOC; and (4) my review of the law challenged in this case. In preparing this report, I have also reviewed the materials listed in the attached bibliography, **Exhibit B.** The sources cited therein are authoritative, scientific peer-reviewed publications. These are the same types of materials that experts in my field of study regularly rely upon when formulating opinions on the subject. I reserve the right to revise and supplement the opinions expressed in this 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.

Discussion

Gender Identity Development and Gender Dysphoria in Children and Adolescents

16. At birth, infants are assigned a sex, either male or female, based on the appearance of their external genitalia. For most people, their sex assigned at birth, or assigned sex, matches that person's gender identity. For transgender people, their assigned sex does not align with their gender identity.

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

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

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

20. The evidence demonstrating that gender identity cannot be altered, either for transgender or for non-transgender individuals, underscores the innate nature of gender identity. Past attempts to "cure" transgender individuals by using talk therapy, and even aversive therapy, to change their gender identity to match their birth-assigned sex were ineffective and caused harm. The major associations

of medical and mental health providers, such as the American Medical Association, the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, the American Psychological Association, and WPATH's standards of care, consider such efforts harmful and unethical.

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

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

Standard of Care for Treatment of Gender Dysphoria in Youth

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

24. Accordingly, the goal of treatment for gender dysphoria is to reduce distress and improve functioning which often occurs through the process of enabling the individual to live consistent with their gender identity. The process of

undergoing those treatments is often referred to as gender transition. The stages that make up a transgender person's gender transition will depend on that individual's medical and mental health needs. The purpose of transition is to allow a transgender person to live congruently with their gender identity, including in many cases undergoing medical treatments to align the person's body with who they are.

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

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

person's identity.

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

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

Safe and Effective Treatments for Gender Dysphoria

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

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

transition. Transgender young people who underwent a social transition in childhood demonstrated better mental health profiles than prior studies of gender nonconforming children. *See* Lily Durwood, et al., *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*, 56 J. Am. Acad. of Child & Adol. Psychiatry 116 (2017); Kristina Olson, et al., *Mental Health of Transgender Children who are Supported in Their Identities*, 137 Pediatrics 1 (2016). This same outcome has also been seen in a longitudinal study of transgender young people who underwent each of the three stages of transition outlined above. Annelou L.C. de Vries, et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014).

31. Gender transition also can—and often does—alleviate co-occurring mental health issues a transgender young person experienced prior to transition. Following transition, transgender young people are often able to reduce dosage of psychiatric medications and see significant improvements in functioning and quality of life. Treating their gender dysphoria also increases a transgender young person's capacity to develop and maintain better coping strategies to manage any co-occurring conditions. For example, a recent study found that after two years of hormone treatment, transgender youth experienced increases in positive affect and life satisfaction and decreases in depression and anxiety symptoms. Diane Chen, et al., *Psychosocial Functioning in Transgender Youth after Two Years of Hormones*,

388 N. Engl. J. Med. 240 (2023).

32. Research shows that gender transition significantly improves the mental health of transgender young people, bringing their mental health profiles into alignment with their non-transgender peers. Kristina Olson, et al., *Mental health of transgender children who are supported in their identities*, 137 Pediatrics 1 (2016);[1] *see also* Jack Turban, et al., *Pubertal suppression for transgender youth and risk of suicidal ideation*, 145 Pediatrics 1 (2020) (transgender people who accessed puberty suppression treatment were 70% less likely to contemplate suicide).

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

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

34. The first objective of a mental health provider treating a child or adolescent who appears to be experiencing gender dysphoria is to conduct a careful and thorough assessment. That assessment allows the provider to accurately

[1] Anxiety was the only area where transgender young people differed from the non-transgender controls. On that measure, transgender young people showed slightly elevated levels of anxiety, but were still in the pre-clinical range.

diagnose the patient, including whether the patient meets the stringent criteria for gender dysphoria and any co-occurring conditions. The foundation of the assessment process is building a detailed history of the patient, such as prior treatment, trauma, substance misuse, among many other factors. That assessment also requires a developmentally informed exploration of the patient's relationship to their gender identity over time that includes information obtained from multiple informants whenever possible.

35. To appropriately conduct that assessment, the mental health provider must draw from their professional training and experience in working with transgender young people, exercise professional judgment, and tailor the assessment to each individual patient and their family. The number of sessions that assessment requires will vary depending on the patient's presentation and the complexity of the issues the patient is navigating. The assessment process also goes beyond gathering information from the patient and their family. The mental health provider will typically gather and review information from the patient's primary care provider, prior mental health providers, and other adult professionals who are part of the patient's care team.

36. A detailed history and assessment are important to provide the context for developing an appropriate treatment plan. That comprehensive assessment is also needed to help inform possible future care plans, such as the patient's need for

puberty blockers or hormone therapy. Once this treatment plan is developed, the mental health provider remains involved in the treatment plan, ensuring that the plan continues to address the patient's individual needs. For example, mental health providers regularly assess the effects of gender dysphoria on a patient's life and functioning. The purpose of that ongoing evaluation is to identify the areas where the patient needs to develop resilience and coping strategies to minimize the effects of their gender dysphoria and to evaluate the mental health benefits of future treatment options.

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

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

equally acceptable outcomes.[2]

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

40. For young people who do meet the diagnostic criteria for gender dysphoria, mental health treatment often involves referring a patient for medical

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

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

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

42. The mental health provider will then document the results of their

assessment in a letter to the patient's treating physician. The letter details the provider's diagnostic analysis as well as any professional opinions regarding the benefits of and readiness for the contemplated treatment. Ultimately, the appropriateness of any medical treatment is determined by a multidisciplinary team of expert mental and medical care providers.

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

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

44. Transgender young people, however, are not outliers in this regard. Research and clinical experience show that most psychiatric conditions are highly correlated with other co-occurring psychiatric conditions. For example, young people with depression are very likely to have at least one other diagnosable condition, most often anxiety. *See, e.g.*, E. Jane Costello, et al., *Prevalence and development of psychiatric disorders in childhood and adolescence*, 60 Archives of Gen. Psychiatry 837 (2003) ("There was strong heterotypic continuity from depression to anxiety" and finding approximately 30% of participants diagnosed

with a depressive disorder were also diagnosed with an anxiety disorder). Likewise, a study on children diagnosed with Attention-Deficit/Hyperactivity Disorder found between 74-79% participants had additional co-occurring psychiatric conditions. Timothy Wilens, et al., *Psychiatric Comorbidity and Functioning in Clinically Referred Preschool Children and School-Age Youths With ADHD*, 41 J. of Am. Academy of Child & Adol. Psychiatry 262 (2002).

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

46. The standards of care recognize that it is not possible for a transgender patient to resolve all co-occurring conditions prior to undergoing medical treatment, nor would it be ethical to impose such a requirement. Resolving all co-occurring conditions before medical treatment is not a requirement for other conditions. Gender dysphoria, by definition, is accompanied by clinically significant psychological distress. That distress can take on many different forms (*e.g.*, anxiety, mood disorders, and depression) and vary greatly in severity, resulting in co-occurring conditions. Because psychological distress is not easily

compartmentalized, the distress associated with gender dysphoria can also amplify co-occurring conditions that developed independently of the gender dysphoria. In either situation, gender dysphoria limits the effectiveness of treatment of any co-occurring mental health conditions. Thus, treating the underlying gender dysphoria is essential to alleviating the psychological distress associated with co-occurring conditions.

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

48. Gender dysphoria is a real and serious medical condition that is highly

treatable. There is a rigorous and comprehensive protocol for diagnosing an individual with the condition. There is also a well-established standard of care for the treatment of gender dysphoria, including for treatment of gender dysphoria in transgender youth with puberty blockers and hormone therapy. When that treatment is provided, transgender youth can thrive. There are studies that have demonstrated that, and my own experience confirms it. In my experience, I have seen mental health providers carefully assess and work with youth, their parents, and other doctors that care for the youth to create a treatment plan that includes continuing mental health care and ongoing assessments.

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

50. I hold each of the opinions expressed in this declaration with a reasonable degree of scientific certainty, based on the materials I have reviewed and on my education, experience, and knowledge. I reserve the right to

supplement, amend, or modify my opinions upon review of further information, including, but not limited to, testimony, documents, and reports I receive after the date of this declaration.

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

Executed this 11th day of April 2023.

Aaron Janssen, M.D.

Exhibit A

Curriculum Vitae

Curriculum Vitae

Aron Janssen, M.D.

Personal Data

Born	Papillion, Nebraska
Citizenship	USA

Academic Appointments

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

Education

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

Postdoctoral Training

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

Licensure and Certification

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

Academic Appointments

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

Major Committee Assignments

International, National and Regional

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

Psychiatry Residency

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

Medical School

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

Memberships, Offices, and Committee Assignments in Professional Societies

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

Editorial Positions

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

Principal Clinical and Hospital Service Responsibilities

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

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

Relevant Program Development

Gender and Sexuality Service

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

-first mental health service dedicated to transgender youth in NYC

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

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

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

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

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

-model has been internationally recognized

Clinical Specialties/Interests

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

Teaching Experience

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

Academic Assignments/Course Development

New York University Department of Child and Adolescent Mental Health Studies

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

NYU Department of Child and Adolescent Psychiatry

-Instructor: Cultural Competency in Child and Adolescent Psychiatry

-Director: LGBTQ Mental Health Elective

World Professional Association of Transgender Health

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

Peer Reviewed Publications

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

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

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

Published Abstracts

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

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

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

Books

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

Book Chapters

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

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

Invited Academic Seminars/Lectures

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

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

Selected Invited Community Seminars/Lectures

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

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

Major Research Interests

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

Research Studies

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

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

Other

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

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

Selected Media Appearances:

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

Exhibit B

Bibliography

BIBLIOGRAPHY

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

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

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

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

Psychologist, 70(9), 832–864.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE, individually and on behalf of her minor daughter, SUSAN DOE, et al.,

Civil No. 4:23-cv-00114-RH-MAF

Plaintiffs,

v.

JOSEPH A. LADAPO, *in his official capacity as Florida's Surgeon General of the Florida Department of Health*, et al.,

Defendants.
_____/

EXPERT DECLARATION OF DR. BRITTANY BRUGGEMAN, M.D.

I, Brittany Bruggeman, M.D., hereby declare as follows.

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

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

I. INTRODUCTION

A. Background and Qualifications

3. I am a licensed physician in Florida and am Double Board Certified by the American Board of Pediatrics in Pediatric Endocrinology and Pediatrics.

4. I am a pediatric endocrinologist at the University of Florida in Gainesville, Florida, and an Assistant Professor at the University of Florida College of Medicine in the Department of Pediatric Endocrinology. I am speaking on behalf of myself as a subject matter expert and not as a representative of the University.

5. I graduated with a Bachelor's of Science degree in Interdisciplinary Studies, Basic Biology and Medicine, from the University of Florida. I received my medical degree from the University of Florida College of Medicine, graduating with Honors in Research.

6. I completed my Residency in Pediatrics and a Fellowship in Endocrinology at the UF Health Shands Children's Hospital.

7. I trained under Dr. Michael Haller, M.D., Professor and Chief of Pediatric Endocrinology at UF, Dr. Janet Silverstein, M.D., founder of the UF Health Youth Gender Program, and Dr. Kristin Dayton, M.D., Director of the UF Health Youth Gender Program. Drs. Haller and Silverstein have each trained hundreds of medical providers, participated in the development of national and international

guidelines, treated thousands of children, held numerous NIH grants and published more than 200 and 140 peer reviewed papers respectively.

8. As a pediatric endocrinologist working in the UF Health Youth Gender Program, I have extensive experience providing treatment for gender dysphoria to transgender minors through a multidisciplinary care model. The Youth Gender Program uses evidence-based standards and practices and has provided social, medical, and mental health support for transgender and gender diverse patients across the state of Florida since 2016.

9. During my time at UF, I received numerous scholarly awards. Most recently, I received the 2022 UF College of Medicine Exemplary Teacher Award that recognizes the top 10% of College of Medicine faculty, and the 2020 Douglas J. Barrett, MD Academic Fellowship Award that recognizes pediatric clinicians or researchers for displaying the highest qualities in research, teaching and patient care. Other awards include the Audrey Lincourt Schiebler Award for Excellence in Child Advocacy (2018), Pediatric Clerkship Excellence in Medical Student Education (2018-19), the Inaugural McJunkin Family Type 1 Diabetes Fellow (2018-19), induction into the Gold Humanism Honor Society (2015), Association of Pathology Chairs Award, UF College of Medicine (2013), Distinguished Service Award, UF College of Medicine (2013), and International Medical Outreach Service Award (2013).

10. I have been a member of the American Academy of Pediatrics (AAP) since 2011, a Diplomat and Fellow of the AAP since 2018, I am a member of the AAP Section on Endocrinology and I served as the AAP's Executive Coordinator of Resident Initiatives for the Section on Pediatric Trainees and the AAP Section on Endocrinology Executive Board fellow representative; I am also a member of the Florida Chapter of the AAP; I have been a Diplomat with the American Board of Pediatric Endocrinology since 2021 and a member of the Pediatric Endocrine Society since 2018; I am a member of the American Diabetes Association, the Florida Medical Association, the Alachua County Medical Society, and Type 1 Diabetes TrialNet, an international network of endocrinologists at the forefront of Type 1 diabetes research.

11. I have served as a Pediatric Attending Physician with the Equal Access Clinic of the UF College of Medicine, a free healthcare clinic, and I have served as both a Camp Physician and volunteer at the Florida Diabetes Camp since 2012.

12. In 2018 as a pediatric endocrinology fellow I began working with transgender children, adolescents and young adults through a multidisciplinary youth gender program. I have provided care for approximately two-hundred transgender young people for gender dysphoria. The best current estimate of the number of transgender patients the multidisciplinary clinic itself has cared for is approximately five-hundred patients. The number of adolescent patients who have

been prescribed hormone blocking medications and/or hormone therapy represent only a portion of all young people who are seen by the clinical team. Therapeutic decisions are individualized- some adolescents are seen in clinic and never receive these treatments, and others are not ready for, or are not candidates for, these medications.

13. Multidisciplinary youth gender clinics provide social, medical and mental health support to gender-diverse youth and young adults and their families. We educate our patients and their families about gender identity development and gender nonconformity, and help empower our patients and families to make informed decisions with accurate information. Teams of professionals include pediatric endocrinologists, psychologists, psychiatrists, pediatricians, social workers, medical-legal partners, and patient care advocates. The care provided is consistent with the World Professional Association for Transgender Health (WPATH) Standards of Care and focuses on the biological, psychological, as well as social (biopsychosocial) components of transgender health. Services provided include consultation, psychotherapy, and assessment of medical indication for hormone blocking medications and/or hormone therapy. In addition to providing expert care, one goal is to provide a safe environment where patients and their families can receive social and emotional supports.

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

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

B. Bases For Opinions

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

17. In addition, I have reviewed the rules promulgated by the Florida Board of Medicine, Rule 64B8-9.019, *Standards of Practice for the Treatment of Gender Dysphoria in Minors*, Fla. Admin. Code (effective March 16, 2023), and the Florida Board of Osteopathic Medicine, Rule 64B15-14.014, *Standards of Practice for the Treatment of Gender Dysphoria in Minors*, Fla. Admin. Code (effective March 28, 2023), which restrict the ability of Florida physicians from providing treatments for gender dysphoria to minors.

C. Prior Testimony

18. I have not testified as an expert at trial or by deposition in the past four years.

D. Compensation

19. I am being compensated for my work on this matter at an hourly rate of $350.00 for preparation of declarations and expert reports, and deposition and trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

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

20. According to the 2022 *Diagnostic and Statistical Manual of Mental Disorders*, *Fifth Edition (DSM-V)*, *Text Revision,* gender dysphoria is a diagnosis defined as an individual having clinically significant psychological distress or impairment in social, occupational or other important areas of functioning that

results from a marked incongruence between their sex assigned at birth and the person's gender identity (the gender with which the individual identifies). Gender dysphoria may manifest in childhood, at the onset of puberty, or in adulthood, and when left untreated it can result in adverse mental health outcomes such as severe anxiety, depression, suicidal ideation and self-harm.

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

22. Comprehensive standards of care and clinical practice guidelines directing this treatment have been developed by the World Professional Association for Transgender Health (WPATH)[1] and by the Endocrine Society.[2] These guidelines

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

[2] Specifically, an Endocrine Society-appointed task force whose Clinical Practice Guidelines were published in The Journal of Clinical Endocrinology & Metabolism in 2017. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2017 Nov 1;102(11): 3869–3903.

have been adopted into practice by the profession as a standard of care. These standards of care are based on decades of scientific and medical research representing the best evidence-based practice information available for treating this condition. The treatment of gender dysphoria with transition-related care is recognized by nearly 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.

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

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

25. Medications for treating gender dysphoria are not recommended for or prescribed to prepubertal children. Instead, support for a prepubertal transgender child may include social transition, which means allowing a child to live and be

socially recognized in accordance with their gender identity rather than their sex assigned at birth. The social transition may include allowing the child to choose clothing, hairstyle, name, pronouns, and activities that correspond to that individual's gender identity.

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

27. Once a transgender adolescent begins puberty, medications can be prescribed to temporarily halt the physical changes of puberty, avoiding the exacerbation of gender dysphoria and mitigating harms that can accompany the development of secondary sex characteristics. Then, if later in adolescence the patient, family, and healthcare team decide that initiation of hormone therapy is in

the patient's best interest, they may be able to avoid physical changes inconsistent with their gender identity.

28. Puberty is initiated by the pulsatile release of the hormone GnRH from the hypothalamus. GnRH then stimulates the pituitary gland to produce Follicle Stimulating Hormone (FSH) and Luteinizing Hormone (LH). These hormones, FSH and LH, then lead to the production of estrogen and testosterone in individuals with ovaries and testes, respectively. Pubertal suppression involves the administration of a medication that prevents the release of FSH and LH, thereby inhibiting the production of estrogen and testosterone. By inhibiting that production, the further development of secondary sex characteristics halts. This pause in puberty limits the further influence of a person's endogenous sex hormones on the body. Stopping the medication resumes the production of FSH and LH and allows puberty to resume with no residual effects on fertility or secondary sex characteristics.

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

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

30. WPATH SOC-8 recommends a multidisciplinary assessment that involves several domains for the patient seeking treatment for gender dysphoria. A licensed mental health professional with expertise in the treatment of transgender and gender diverse adolescents assesses the patient's gender identity development, social development, and the support structure for the patient, including an investigation of the effects of gender minority stress, family dynamics and any other aspect that might contribute to the individual's social development. Additionally, co-occurring mental health and/or developmental concerns are addressed. The mental health professional also assesses whether the minor has the emotional and cognitive maturity to provide informed assent for any treatment. This process of consent and assent involves an evaluation of the minor's and guardian's understanding of the medical information and treatment, including the option to not receive treatment, risks and reversible and irreversible effects of treatment, and fertility options and considerations during an open discussion about the patient's goals and expectations of treatment.

31. The Endocrine Society Guideline specifies that mental health clinicians who diagnose gender dysphoria should be trained "in child and adolescent developmental psychology and psychopathology," competent in using the DSM

and/or ICD diagnostically, and able to understand the individual's mental health, social conditions and ability to consent. This process is highly individualized; a nuanced approach is indicated as each patient has unique medical needs.

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

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

33. Pursuant to the Endocrine Society Guideline, transgender adolescents with gender dysphoria may be eligible for pubertal blocking medication if a qualified mental health professional has confirmed that: (i) the adolescent has demonstrated a

[3] Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *Int J Transgend Health*. 2022 Sep 6;23(Suppl 1):S60.
[4] Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2017 Nov 1;102(11): 3876.

long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed); (ii) gender dysphoria worsened with the onset of puberty; (iii) any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment; and (iv) the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment.

34. Further, the adolescent must: (i) have been informed of the effects and side effects of treatment (including potential impacts on fertility *if* the individual subsequently continues with life-long sex hormone treatment) and options to preserve fertility; and (ii) has given informed consent and the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

35. Lastly, a pediatric endocrinologist or other clinician experienced in pubertal assessment should: (i) agree with the indication for GnRH agonist treatment; (ii) confirm that puberty has started in the adolescent; and (iii) confirm that there are no medical contraindications to GnRH agonist treatment.[2]

36. For transgender adolescents to be eligible for hormone therapy, the Endocrine Society Guideline directs that a qualified mental health professional confirms: (i) the persistence of gender dysphoria; (ii) any coexisting psychological,

medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start hormone therapy; and (iii) the adolescent has sufficient mental capacity to estimate the consequences of this treatment, weigh the benefits and risks, and give informed consent to this treatment.[2]

37. Further, the adolescent needs to have: (i) been informed of the effects and side effects of treatment (including options to preserve fertility); (ii) given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

38. And lastly, a pediatric endocrinologist or other clinician experienced in pubertal induction: (i) agrees with the indication for hormone therapy; and (ii) has confirmed that there are no medical contraindications to hormone therapy.[2]

III. THE MULTIDISCIPLINARY TREATMENT TEAM MODEL

39. I treat transgender patients as part of a multidisciplinary treatment team, which includes psychologists, psychiatrists, pediatricians, pediatric endocrinologists, medical-legal partners, and patient care advocates, all of whom are experienced in providing care to transgender minor patients.

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

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

42. Some patients are referred to the clinic by a mental health provider with expertise in transgender health, while others are referred by their pediatrician or another provider. If the patient does not already have a mental health provider, I refer the patient to one to begin the mental health evaluation prior to providing any treatment. We then work together collaboratively to assess the patient in accordance with the WPATH standards and Endocrine Society guidelines.

43. The mental health provider assesses the patient in the domains described in paragraph 33 and 36. I then review the mental health assessment and confirm that there is a diagnosis of gender incongruence and that it has been consistent, persistent and insistent, along with confirming other relevant criteria. For most of my patients, gender dysphoria has been present for years prior to their first visit with the youth gender clinic. I further assess the patient for any medical or psychosocial conditions that might affect treatment. My interview with the patient and parent or guardian includes a thorough discussion of the patient's individual

needs, goals, and their process of coming to understand and live in accordance with their gender identity.

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

45. As part of my informed consent process, I fully review a packet of information with the adolescent and guardian, which discusses in detail the risks, benefits, and reversible and long-term effects of the relevant medications (pubertal suppressants and/or hormone therapies), and alternatives to treatment. As part of this process, I ask detailed questions to the patient and guardian to ensure understanding of the range of potential treatment options and outcomes. Additional resources and a follow-up protocol are also items in the packet that are reviewed.

46. The patient and guardian then take the informational packet home for self-study. I offer additional reading material when necessary. Once a full evaluation has been completed; the patient, family, and healthcare team are all in agreement

that a treatment is in the best interest of the patient; and risks and benefits are well understood, informed consent and assent are obtained and treatment can commence.

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

48. Consistent with the established treatment guidelines described above, I consider prescribing puberty blocking treatment starting at pubertal Tanner Stages II–III. Please refer to paragraph 52 for a detailed discussion of pubertal timing and other uses of pubertal suppressive medications. Depending on the needs of the patient, the pubertal stage they are in, and any changes that may have already resulted from endogenous puberty, patients may first initiate puberty blocking medication, followed by hormone therapy *if and when* it is medically indicated and the patient and family desire this treatment; or they may initiate hormone therapy alone or in conjunction with androgen receptor antagonists or pubertal suppressants

at later stages of puberty. The goal of the treatment is to minimize the patient's gender dysphoria and to allow the patient to experience secondary sex characteristics consistent with their gender identity if medically indicated and agreed upon by the healthcare team, patient and family.

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

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

50. I have read the Florida Boards of Medicine and Osteopathic Medicine rules that bar doctors from prescribing puberty blocking, hormone antagonist, and hormone therapies for transgender youth. These bans stand in direct contrast to the authoritative standards of care for the treatment of gender dysphoria. Based on my expert opinion, unless enjoined these rules will continue to cause harm to my patients and countless other transgender adolescents in the state of Florida.

51. The Endocrine Society's and WPATH's treatment protocols for prescribing puberty blocking medications and hormone therapies provide an evidence-based, safe and effective treatment approach for gender dysphoria. The American Academy of Pediatrics, which was founded in 1930 and represents more

than 67,000 pediatricians in this country, is one of many reputable medical associations in the United States which supports the use of puberty blocking medications and hormone therapy to treat gender dysphoria in adolescent patients when medically indicated.

52. Puberty blocking treatment works by pausing endogenous puberty at whatever stage it is at when the treatment begins, limiting the further influence of endogenous hormones until the treatment is ended. Puberty blocking medications are not new for the treatment of gender dysphoria, as their use began in Amsterdam in 1998 and expanded to the United States in 2010. There is over 30 years' worth of data on the safety of puberty blockers regarding children who experience precocious puberty that can be applied to the transgender population. In appropriate candidates, the benefits of treating gender dysphoria with puberty blocking medication can greatly outweigh the small potential for short- or long-term side effects. Moreover, for youth with gender dysphoria, as compared to those treated for precocious puberty, the treatment is typically used for a much shorter period to pause development before either initiating puberty with hormone therapy or resuming endogenous puberty.

53. Pubertal development has a wide variation among individuals. The onset of puberty in individuals whose sex assigned at birth is male begins, on average, at age 11-12 but can range from age 9 to 14. In those whose sex assigned

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

54. The use of puberty blocking medications are safe and effective, and the rare side effects are thoroughly discussed with the patient and their family prior to starting any treatment. To address the risk of lower bone mineral density that can be associated with prolonged use of puberty blockers, we conduct regular screening for vitamin D and calcium deficiency (and treat deficiencies when needed), advise regular weight-bearing exercise, conduct bone mineral density scans at regular intervals, and limit the number of years a patient is on puberty blocking medication. Decades of data on the use of puberty blockers as treatment for precocious puberty

has demonstrated that puberty blocking medication does not have long-term implications for fertility.[5,6]

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

56. In a 2020 study published in the American Academy of Pediatrics' official journal *Pediatrics*, researchers queried a group of 20,619 transgender individuals and found a lower odds of lifetime suicidal ideation for those who received pubertal suppression when they were adolescents compared with a group

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

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

that desired pubertal suppression but did not receive it.[7] Suicidality is of particular concern because the estimated lifetime prevalence of suicide attempts among the transgender population is as high as 40%.

57. Under the Endocrine Society Guidelines and WPATH SOC-8, hormone therapy is appropriate for transgender adolescents with gender dysphoria when their experience of gender incongruence is marked and sustained over time, the adolescent demonstrates emotional and cognitive maturity required to provide informed consent/assent for treatment, other mental health concerns (if any) that may interfere with diagnostic clarity and capacity to consent have been addressed, and the adolescent has discussed reproductive options with their provider. For adolescents who meet these criteria, it may be in the patient's best interest to provide hormone therapy to initiate puberty consistent with the patient's gender identity. The parent or guardian is critical to the assessment and treatment process for minors and must provide informed consent for any individual under the age of majority.

58. Hormone therapy is safe and has been used in non-transgender patients for reasons unrelated to the treatment of gender dysphoria. There are a variety of medical conditions in childhood and adulthood where estrogen or testosterone are prescribed, such as polycystic ovary syndrome, menorrhagia (heavy menstrual

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

bleeding), acne, contraception, menopause, post-chemotherapy, premature ovarian failure, pubertal delay, and testosterone deficiency. Patients with various intersex conditions, such as Turner Syndrome or Klinefelter Syndrome, also often receive hormone therapy. Those individuals with the conditions described often need hormone therapy for the duration of their entire lives.

59. As with puberty blocking medications, I discuss the risks and benefits of hormone therapy at length with adolescent patients and their families prior to initiation of treatment. Potential impact on fertility is always discussed along with fertility preservation options. If desired after our discussion, patients are referred to a reproductive endocrinologist for further discussion of fertility preservation, a procedure that also may be recommended prior to certain chemotherapy regimens or due to ovarian or testicular insufficiency.

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

61. The goal of hormone therapy is to lessen gender dysphoria, improve functioning and avoid unwanted secondary sex characteristics while developing characteristics that align with gender identity. Studies have showed improved psychological functioning, body image and mental health, and less gender

dysphoria, suicidality, depression and anxiety with treatment for gender dysphoria. Some of my patients who are receiving medical treatment for gender dysphoria experienced suicidal ideation and attempts prior to beginning treatment. I have witnessed patients transform from individuals with significant levels of psychological distress to functional, psychologically stable, thriving individuals. I fear that categorically denying puberty blockers, hormone antagonists, and hormones to transgender adolescents who meet criteria for care will lead to distress and psychological harm.

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

63. In summary, the interventions described above are effective and safe, and access is essential for the wellbeing of those transgender adolescent patients for whom they are indicated. The treatments are provided only with assent from the patient and consent from the parent or guardian. My patients who receive medically necessary treatment for gender dysphoria often experience significant improvement in their mental health and quality of life. Medical treatment recommended for and provided to transgender adolescents with gender dysphoria can substantially reduce

lifelong gender dysphoria and can eliminate the potential need for later, more invasive treatments. Access to medications to treat gender dysphoria is vital and can improve the short- and long-term health outcomes for transgender adolescents.

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

64. I have reviewed the medical bans promulgated by the Florida Boards of Medicine and Osteopathic Medicine. Based on my review, I understand those rules to prohibit board-certified physicians like myself from following accepted standard of care in providing medical treatment for gender dysphoria for minors who had not received treatment prior to March 16, 2023 and March 28, 2023, respectively.

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

66. Since the Boards' rules have become effective, I have met with new patients who were candidates for puberty blocking medication or hormone therapy,

but physicians, including myself, are not permitted to prescribe them. The parents of these adolescents are angry and concerned for their children. They want to ensure their children get the medical care that they need to live happy, productive and healthy lives. There are several families who are taking active steps to move out of the state of Florida. It is devastating that these parents feel that they have no other option but to leave and find a safe place for their children, who will be denied critical medical treatment if they remain in Florida.

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

68. Many of my transgender patients' anxiety, depression, and self-harming behaviors have improved following the initiation of treatment for gender dysphoria. I have witnessed myriad patients transform from being withdrawn, sullen, and unable to connect, to thriving socially, developing self-confidence, and developing close friendships. Not only have I seen this growth in my patients during

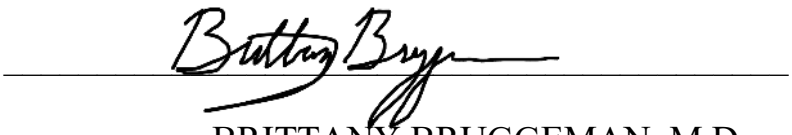
our clinical visits, but many of my patients' parents have expressed to me how their teenage child blossomed and came out of their shell after receiving treatment for gender dysphoria. Many of my patients' parents have also shared with me how crippling and painful it was as a parent to watch their child struggle without access to necessary medical care, and it haunts me to know that under the Boards' rules, so many more parents are going to have to watch their children suffer without access to effective treatment for their gender dysphoria.

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

and well-documented. The Florida Boards of Medicine bans prohibit doctors from caring for their patients and abiding by the Hippocratic Oath.

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

Executed this 20th of April, 2023.



BRITTANY BRUGGEMAN, M.D.

Exhibit A

Brittany S. Bruggeman

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Education

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B.S., Basic Biology and Medicine 2008-2012
Minor, Music Performance
Summa cum laude
Thesis: "Development and Optimization of a Bioartificial Pancreas as a Therapy for Type 1 Diabetes."

M.D., College of Medicine 2011-2015
Medical Honors Program
With Honors in Research

UF Health Shands Children's Hospital, Gainesville, FL

Pediatric Residency 2015-2018
Research Track

Endocrinology Fellowship 2018-2021

Qualifications & Licensure

USMLE Step 1: 247	2013
USMLE Step 2: 267	2014
USMLE Step 3: 242	2015
Diplomat, American Board of Pediatrics	2018-present
Fellow, American Academy of Pediatrics	2018-present
Florida Medical Licensure: ME 137728	2018-present
Diplomat, American Board of Pediatric Endocrinology	2021-present

Current Appointments

Assistant Professor of Pediatric Endocrinology, Tenure-eligible
University of Florida | Gainesville, FL July 2021-present

Honors and Awards

Internal

UF College of Medicine Exemplary Teacher Award 2022
Annual award that recognizes the top 10% of College of Medicine faculty in teaching excellence and mentorship.

2020 Douglas J. Barrett, MD Academic Fellowship Award 2020-2021

Awarded to one rising third or fourth year pediatric clinical or research fellow displaying the highest qualities of scholarly activity in research, teaching and patient care. Funds one year of fellowship training.

Pediatric Clerkship Excellence in Medical Student Education x3, 2018-2019
Medical students recognize one resident or faculty who most positively impacted their education during their pediatric clerkship.

Inaugural McJunkin Family Type 1 Diabetes Fellow 2018-2019
Awarded to fellows committed to careers as clinician-scientists in type 1 diabetes. Funds one year of pediatric endocrinology fellowship.

Audrey Lincourt Schiebler Award for Excellence in Child Advocacy 2018
Awarded to one UF pediatric trainee for superior efforts in child advocacy.

Best Resident/Fellow Poster, UF Pediatric Science Day May 2017
"Prevalence and Characterization of Retinopathy in Children with Type 1 Diabetes Using a Non-mydriatic Fundus Camera."

Gold Humanism Honor Society, UF Chapter Jan. 2015- present
15% of the fourth-year medical school class selected for exemplary behavior that promotes humanism in medicine.

Association of Pathology Chairs Award, UF College of Medicine May 2013

Distinguished Service Award, UF College of Medicine (COM) May 2013

International Medical Outreach Service Award, UF COM May 2013

External

NIH NIDDK Travel Award June 2022
One of six abstracts chosen for oral presentation at the "Integrated Physiology of the Exocrine and Endocrine Compartments in Pancreatic Diseases Workshop."

CAPER 2022 PancreasFest Travel Grant May 2022
Awarded to trainees and early career faculty dedicated to pancreatic research.

Runner-Up, Best Case Presentation ISPAD Science School May 2021
Awarded to the top five case presentations at the ISPAD Science School for Physicians in May 2021. Winning presentations were developed into modules on the ISPAD e-learning platform.

American Academy of Pediatrics (AAP) Top Ten Resolution 2019
First-authored resolution, "Affordable Insulin Access for All Children with Diabetes" voted by AAP leadership to be a top 10 policy priority in 2019 out of 60+ accepted proposals.

Endocrine Society Presidential Poster Competition Participant March 2019

First-authored top-scoring abstract for presentation at the Annual Meeting.

Third Place Oral Presentation, FCAAP Pediatric Medical Student Research Forum Aug. 2014
"Comparison of effectiveness of Glulisine, Lispro, and Aspart in decreasing post-prandial hyperglycemia in a real-world setting."

Service and Leadership

Internal

Equal Access Clinic, UF College of Medicine
Pediatric Attending Physician 2018-present
UF College of Medicine student-run free healthcare clinic

Gainesville Healthy Smiles Day
Founder and Organizer April 2016 & June 2017
Pediatric Residents trained in oral health exams and provided free basic dental care, education, and referrals in an underserved area of Gainesville.

Global Health Outreach Medical Missions
Trip Member, Nicaragua 2012, 2014, 2015
Trip Leader, Nicaragua 2013

PACE Center for Girls
UF College of Medicine Careers in Medicine Day July 2022

UF College of Medicine
LCME Accreditation Review Jan. 2023
Pediatric Residency Advocacy Rotation Co-Director July 2022-present
Research Accountability Team member December 2021-present
Collaborative Learning Group Leader July 2021-present
Team Lead, FL DOH CMS Endocrine Disease Mgmt. Contract 2020-2022
Pediatric Interest Group Treasurer 2012-2013

UF College of Medicine White Coat Company
Vocal coach and participant Aug. 2011-May 2013

External

Alachua County Medical Society
Secretary/Treasurer May 2021-present
Trainee Advisory Board Member 2018-2021

American Academy of Pediatrics

Adopted first-authored resolution: "Equitable Parental Leave Recommendations for Pediatric Trainees"	Aug. 2021
Section on Endocrinology Executive Board Fellow Member	2019-2021
Executive Coordinator of Internal Process for the Section on Pediatric Trainees (SOPT)	2018-2019
Executive Coordinator of Resident Initiatives, SOPT	2017-2018
Resolutions Task Force, SOPT	2017-2018
District X Resident Representative, SOPT	2016-2017
District X Assistant District Coordinator, SOPT	2015-2016
Residency Program Delegate	2015-2018

American Diabetes Association

National Advocacy Committee Member	Jan 2021-present
Early Career Advisory Group Member	March 2021-present
Legislative and Regulatory Subcommittee Member	2019-2020
Call to Congress Participant	April 2019

Florida Chapter of the American Academy of Pediatrics

Early Career Committee Member	2019-2021
Legislative Committee Co-Chair	Nov. 2022-present

Florida Diabetes Camp

Volunteer	July 2012, 2014, 2016 & 2017
Camp Physician	July 2018, 2022

The Environmental Determinants of Diabetes in the Young Study

Diet Committee	2022-present

Type 1 Diabetes TrialNet

Microbiome Working Group	2021-present
Populations Working Group	2019-2022
Psychosocial Committee	2023-present

Professional Affiliations

American Academy of Pediatrics (AAP), Member	2011-present
Alachua County Medical Society, Member	2017-present
AAP Section on Endocrinology, Member	2018-present
American Diabetes Association, Member	2018-present
Florida Medical Association, Member	2018-present
Network for Pancreatic Organ Donors with Diabetes, Investigator	2018-present
Pediatric Endocrine Society, Member	2018-present

Professional Development

American Academy of Pediatrics (AAP)

Washington, DC Legislative Office Internship	April 2018
Annual Legislative Conference	2017, 2018
Section on Pediatric Trainees Planning Meeting	2016, 2018, 2019
District IX/X Annual Meeting	2016, 2017
National Conference and Exhibition	Annually 2012-2020

Florida Chapter of the AAP

Annual Meeting Residency Brain Bowl Participant	2016 & 2017
Annual Conference	2014, 2016-2018, 2020-2022

American Diabetes Association

Focus on Fellows Annual Meeting	Annually 2018-2021
Scientific Sessions	Annually 2018-2022

American Pediatric Society/Society for Pediatric Research

APS SPR Journeys & Frontiers in Pediatric Research Program	2021-2022

Association for Clinical and Translational Science

Annual Meeting	2022
Mock NIH K Study Section	2022

Children with Diabetes Friends for Life

Fellows Program	2018
Annual Meeting	2018

Collaborative Alliance for Pancreatic Education and Research

CAPER PancreasFest Annual Meeting	2022

The Endocrine Society

Fellows Series: Type 1 Diabetes Care and Management Conference	2019
Annual Meeting	2019

Florida Medical Association

Legislative Visitation Program	April 2019
Annual Conference Delegate	2017, 2022

International Society for Pediatric and Adolescent Diabetes

Science School for Physicians	May 2021

Network for Pancreatic Organ Donors with Diabetes (nPOD)

Annual Meeting	2020, 2022, 2023

NIH NIDDK

Integrated Physiology of the Exocrine and Endocrine Compartments in Pancreatic Diseases Workshop	2022

Pediatric Academic Societies
Annual Conference 2013

Pediatric Endocrine Society
Annual Meeting 2019, 2021, 2022

Southern Pediatric Endocrine Society
Annual Meeting 2019

The Environmental Determinants of Diabetes in the Young (TEDDY)
Steering Committee Meeting 2022

Type 1 Diabetes TrialNet
Steering Committee Meeting 2019, 2020, 2022

UF Graduate-Level Research Courses Completed
GMS6945 Team Science Fall 2021
PHC6052 Introduction to Biostatistical Methods Fall 2021
GMS6875 Ethical/Policy Issues in Clinical Research Spring 2022
GMS6885 Translational Health Research Design Fall 2022

Reviewer

Alachua County Medical Society
ACMS Poster Symposium Judge 2021, 2022

American Academy of Pediatrics
Legislative Conference Scholarships, Section on Pediatric Trainees (SOPT) 2017, 2018
Anne E. Dyson Child Advocacy Award, SOPT 2017, 2018
National Conference Resident Clinical Case Presentations 2016- 2018

Pediatric Endocrine Society
2023 Annual Meeting Abstracts 2023

Ad hoc reviewer for:
Case Reports in Endocrinology 2020-present
Diabetes Care 2018-present
Diabetes Technology and Therapeutics 2019-present
Diabetes Therapy 2019-present
Diabetes UK 2022-present
Diabetologia 2019-present
JMIR Diabetes 2021-present
Pediatric Diabetes 2018-present
Pediatrics 2020-present

Pediatrics in Review 2021-present

Mentorship

University of Florida Undergraduate Research Assistants

Logan Brunson	Oct. 2018-May 2020
McKayla Massey	Oct. 2018-May 2020
Daniel Rodriguez	Oct. 2018-May 2020
Michael Guyot	June 2022-present
Christopher Georgas	Nov. 2022-present
Danielle Elliott	Nov. 2022-present

UF COM Medical Student Research Assistants

Savanna Gornisiewicz	June 2022-present
Ryan Grabau	June 2022-present
Camila Sarcone	June 2022-present
Rebecca Oyetoro	June 2020-March 2021
Amanda LaPorte	June 2015-Dec. 2018

UF Pediatric Residency Intern Mentorship Program

Iriyise Oloruntoba-Oju	July 2021-present

UF Pediatric Endocrinology Fellow Scholarship Oversight Committee

Israa Ismail	October 2021-present

Mentee Awards

Savanna Gornisiewicz, *2022 Alachua County Medical Society Poster Symposium finalist,* "Serum Exocrine Enzymes as Biomarkers of Response to Immunotherapy in Type 1 Diabetes." Received $500 scholarship.

Camila Sarcone*, 2022 Medical Student Research Program Symposium semi-finalist*, "Chronic pancreatitis and acinar atrophy by histopathology characterize young nPOD donors with reduced pancreas organ weight and may precede this finding in the progression to type 1 diabetes." Received $100 prize.

Michael Guyot, *2023-2024 University of Florida AI Scholars Program*, "The development of a MACSima imaging cyclic staining (MICS) panel to evaluate exocrine pancreatic pathology in type 1 diabetes (T1D)." Received $1750 scholarship.

Invited Panels

Internal

UF College of Medicine
BMS 6091: Health Outcomes and Policy 1, Expert Panel Consult Jan. 2020, 2021
Intern 101 Pediatric Pathway: LGBTQ Panel May 2022

External

American Academy of Pediatrics
National Conference and Exhibition Residency Admissions Panel Nov. 2018

Network for Pancreatic Organ Donors with Diabetes (nPOD)
15th Annual Scientific Meeting "WIELD panel: What Brings You Joy? How to Choose a Career Path in T1D Women in Diabetes Research" March 2023

WGCU Public Media
"Blood Sugar Rising" Panel Discussion Nov. 2020

Invited Lectures

Internal

Medi-Gators Virtual Shadowing Program
"A Day in the Life of a Pediatric Endocrinologist." October 2021

UF Child & Adolescent Psychiatry Fellowship Program
"Hormonal Treatment for Gender Dysphoria." March 2022

UF College of Medicine
BMS 6632: "Intro to Diabetes: Types, Stigma, & Complications." 2022, 2023
BMS 6632: "DKA & HHS: Case-based Learning." 2022, 2023
Intern 101 Pediatric Pathway: "Diabetes in Children." May 2022

UF Neonatal Grand Rounds
"Sexual Differentiation and Related Disorders." Nov. 2021, March 2023

UF OB/GYN Grand Rounds
"OB/GYN care of transgender and gender-diverse patients." Nov. 2021

UF OB/GYN Clerkship
Case-based conference: "Amenorrhea and delayed puberty." March 2023

UF Pediatric Grand Rounds
"Hot Topics- 3 Minute Talks. Natural History and Mechanisms of Exocrine Dysfunction in Pre-Type 1 Diabetes." May 2021
"Pediatric Obesity: Avoiding the Pitfalls of Stigma, Bias, and Inertia in Patient Care." October 2021

UF Pediatric Endocrinology Core Lectures

"Placental Passage of Hormones" February 2022
"Sexual Differentiation and Related Disorders." March 2023

UF Pediatric Residency Program
"Diabetes Logistics" July 2019
"Precocious Puberty" July 2019, Aug 2022

UF Pensacola Pediatric Residency Program
"Cushing Syndrome" March 2021

External

American Academy of Pediatrics
Section on Oral Health Webinar "Adding Oral Health to Your Advocacy Agenda." Feb. 2018
National Conference and Exhibition Section on Pediatric Trainees Resident Breakout, "SOPT Delegate 101." Nov. 2018

American Diabetes Association
ADA Focus on Fellows, "Patient Advocacy." June 2021
ADA Focus on Fellows, "Identifying Funding." June 2021
Webinar, "Standards of Care in Diabetes 2023 Update for Early Career Professionals." Jan. 2023

Lohman Family Diabetes & Wellness Conference
"Advancements & Opportunities in the Care of Children with Diabetes" Nov 2021

Right Care Alliance
UF Town Hall, "Insulin Access and Affordability." July 2018
UF Diabetes Awareness Fair, "Insulin Access and Affordability." Nov. 2018

Southern Pediatric Endocrine Society
Annual Meeting, "Insulin Affordability for Pediatric Diabetes Patients." Feb. 2019

Rotary Club of Marco Island
"The COVID-19 Pandemic and Diabetes Care" Jan. 2021

Bibliography

Peer-Reviewed Manuscripts

1. **Bruggeman BS**, Walker AF, Peters AL, D'Avolio LW, Haller MJ. "Blue Circle Health: A novel patient-centered model of health care delivery for low-income patients with type 1 diabetes." *J Diabetes Sci Technol*. 2023;0(0). https://doi.org/10.1177/19322968221149008

2. So M, O'Rourke C, Ylescupidez A, Bahnson HT, Steck AK, Wentworth JM, **Bruggeman BS**, Lord S, Greenbaum CJ, Speake C. "Characterizing the Age-dependent Effects of Risk Factors on Type 1 Diabetes Progression." *Diabetologia* 2022 Apr;65(4):684-694. https://doi.org/10.1007/s00125-021-05647-5
3. Crossen SS, **Bruggeman BS**, Haller MJ, Raymond JK. "Challenges and Opportunities in Utilizing Telehealth for Diabetes Care." *Diabetes Spectr.* 2022 Feb 15;35(1):33-42. https://doi.org/10.2337/dsi21-0018
4. Zimmerman C, Ilstad-Minnihan A, **Bruggeman B**, Bruggeman B, Dayton K, Joseph N, Moas D, Rohrs H. "Thyroid Storm Caused by Hyperemesis Gravidarum." *AACE Clin. Case Rep*. 2022 Jan 3;8(3):124-127. https://doi.org/10.1016/j.aace.2021.12.005
5. **Bruggeman BS**, Campbell-Thompson M, Filipp SL, Gurka MJ, Atkinson MA, Schatz DA, Jacobsen LM. "Substance use affects type 1 diabetes pancreas pathology: implications for future studies." *Front Endocrinol*. 2021 Nov;12:1553. https://doi.org/10.3389/fendo.2021.778912
6. **Bruggeman BS**, Bernier A. "Hirsutism and Menstrual Irregularity in a 16-year-old Girl." *Pediatr Rev*. 2021 Aug;42(8):449-452. https://doi.org/10.1542/pir.2020-002089
7. Lin AS, Mack JA, **Bruggeman B,** Jacobsen LM, Posgai AL, Wasserfall CH, Brusko TM, Atkinson MA, Gitelman SE, Gottlieb PA, Gurka MJ, Mathews CE, Schatz DA, Haller MJ. "Low-dose ATG/GCSF in Established Type 1 Diabetes: A Five-Year Follow-up Report." *Diabetes*. 2021 May;70(5):1123-1129. https://doi.org/10.2337/db20-1103
8. **Bruggeman B**,* Zimmerman C,* LaPorte A, Stalvey M, Filipp SL, Gurka MJ, Silverstein JH, Jacobsen LJ. "Barriers to Retinopathy Screening in Youth and Young Adults with Type 1 Diabetes." *Pediatr Diabetes*. 2021 May;22(3):469-473. https://doi.org/10.1111/pedi.13171 ***Equal first authorship**
9. Foster TP, **Bruggeman B**, Guedes B, Dayton K. "Seizure Activity in a 3-year-old Girl." *Pediatr Rev*. 2021 Jan;42(S1):S85-S88. https://doi.org/10.1542/pir.2019-0252
10. Foster TP, **Bruggeman B**, Campbell-Thompson M, Atkinson MA, Haller MJ, Schatz DA. "Exocrine Pancreas Dysfunction in Type 1 Diabetes." *Endocr Pract.* 2020 Dec;26(12):1505-1513. https://doi.org/10.4158/EP-2020-0295
11. **Bruggeman BS,** Vincent HK, Chi X, Filipp SL, Mercado R, Modave F, Guo Y, Gurka MJ, Bernier A. "Simple tests of cardiorespiratory fitness in a

pediatric population." *PLOS ONE*. 2020 Sep;15(9):e0238863. https://doi.org/10.1371/journal.pone.0238863

12. Zimmerman C,***** **Bruggeman B,*** LaPorte A, Kaushal S, Stalvey M, Beauchamp G, Dayton K, Hiers P, Filipp SL, Gurka MJ, Silverstein JH, Jacobsen LJ. "Real-world Screening for Retinopathy in Youth with Type 1 Diabetes Using a Non-mydriatic Fundus Camera." *Diabetes Spectr*. 2020 Sep; ds200017. https://doi.org/10.2337/ds20-0017 ***Equal first authorship**
13. Morris HL, Donahoo WT, **Bruggeman B**, Zimmerman C, Hiers P, Zhong VW, Schatz D. "An Iterative Process for Identifying Pediatric Patients with Type 1 Diabetes: Retrospective Observational Study." *JMIR Med Inform*. 2020 Sep;8(9):e18874. https://doi.org/10.2196/18874
14. Walker AF, Haller MJ, Gurka MJ, **Bruggeman B**, Miller K, Foster N, Anez Zabala C, Schatz DA. "Addressing Health Disparities in Type 1 Diabetes through Peer Mentorship." *Pediatr Diabetes.* 2020 Feb;21(1):120-127. https://doi.org/10.1111/pedi.12935
15. **Bruggeman BS**, Albanese-O'Neill, A. "From Pediatric to Adult Diabetes Care: Strategies for Success." *Practical Diabetology.* 2019 Aug. Retrieved from: https://www.diabetesselfmanagement.com/practical-diabetology/news-tools/pediatric-adult-diabetes-care-strategies-success/
16. **Bruggeman BS**, Schatz DA. "Enhanced Understanding of the Natural History of Pre-Type 1 Diabetes: Fundamental to Prevention." *Pediatr Endocrinol Rev.* 2019 Mar;16(3):359-368. https://doi.org/10.17458/per.vol16.2019.bs.pretype1diabetes

Expert Commentary

1. **Bruggeman BS**, Schatz DA. "The ISPAD Clinical Practice Consensus Guidelines 2022: how far we have come and the distance still to go." *Lancet Diabetes Endocrinol*. 2023 Mar 24;S2213-8587(23)00083-9. https://doi.org/10.1016/S2213-8587(23)00083-9
2. **Bruggeman BS**, Campbell-Thompson MC. Expert Commentary, "2-Year Remission of Type 2 Diabetes and Pancreas Morphology." *Practice Update* October 2020. https://www.practiceupdate.com/content/2-year-remission-of-type-2-diabetes-and-pancreas-morphology/107876
3. **Bruggeman BS**. "Fertile, fat, and forty." *The Yale Journal for Humanities in Medicine.* 11 May 2014. http://yjhm.yale.edu/essays/bbruggeman20140511.htm

Peer-Reviewed Conference Proceedings and Abstracts

International/National Presentations

1. Guyot M, Williams M, Bumgarner BM, Brusko M, Campbell-Thompson M, Wasserfall C, **Bruggeman B**. "The development of a MACSima imaging cyclic staining (MICS) panel to evaluate exocrine pancreatic pathology in type 1 diabetes (T1D)." Poster at *Network for Pancreatic Organ Donors with Diabetes 15th Annual Meeting*, February 2023.
2. Sarcone C, Turk L, Jacobsen L, Campbell-Thompson M, **Bruggeman B**. "Chronic Pancreatitis and Acinar Atrophy by Histopathology Characterize Young nPOD Donors with Reduced Pancreas Organ Weight and May Precede this Finding in the Progression to Type 1 Diabetes." Poster at *Network for Pancreatic Organ Donors with Diabetes 15th Annual Meeting*, February 2023.
3. **Bruggeman BS**, Gornisiewicz S, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D. "Serum Exocrine Enzymes as Biomarkers of Response to Immunotherapy in Type 1 Diabetes." Oral presentation at *NIH NIDDK Integrated Physiology of the Exocrine and Endocrine Compartments in Pancreatic Diseases Workshop,* June 2022.
4. **Bruggeman BS**, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D. "A Serum Exocrine Enzyme as a Biomarker of Response to Immunotherapy in Type 1 Diabetes." Poster at *CAPER PancreasFest,* July 2022.
5. **Bruggeman BS**, Gornisiewicz S, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D. "Serum Exocrine Enzymes as Biomarkers of Response to Immunotherapy in Type 1 Diabetes." Oral presentation at *NIH NIDDK Integrated Physiology of the Exocrine and Endocrine Compartments in Pancreatic Diseases Workshop,* June 2022.
6. Gornisiewicz S, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D, **Bruggeman BS**. "Serum Exocrine Enzymes as Biomarkers of Response to Immunotherapy in Type 1 Diabetes." Poster at *NIH NIDDK Integrated Physiology of the Exocrine and Endocrine Compartments in Pancreatic Diseases Workshop,* June 2022.
7. **Bruggeman BS**, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D. "A Serum Exocrine Enzyme as a Biomarker of Response to Immunotherapy in Type 1 Diabetes." Poster at *Association for Clinical and Translational Science Annual Meeting,* April 2022. https://doi.org/10.1017/cts.2022.192
8. **Bruggeman BS**, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D. "A Serum Exocrine Enzyme as a Biomarker of Response to Immunotherapy in Type 1 Diabetes." Poster at *Pediatric Endocrine Society Annual Meeting,* April 2022.

9. Zimmerman C, Ilstad-Minnihan A, **Bruggeman B**, Bruggeman B, Dayton K, Joseph N, Moas D, Rohrs H. "Thyroid Storm Caused by Hyperemesis Gravidarum." Poster at *American Association of Clinical Endocrinology Annual Meeting 2021: Envision*. Virtual. May-June 2021.
10. **Bruggeman B.** "Mechanisms of Exocrine Dysfunction in Type 1 Diabetes." Oral Presentation at *Seventh Annual Endocrine Fellows Foundation Diabetes, Obesity, and Metabolism Research Forum*. February 2021.
11. **Bruggeman BS**, Beachy D, Jacobsen LM, Nick HS, Atkinson MA, Schatz D, Wasserfall C. "Role of mTORC1 Regulation in the T1D Organ Donor Pancreas." Poster at *American Diabetes Association Annual Meeting*, June 2020. https://doi.org/10.2337/db20-1637-P
12. **Bruggeman BS**, Bernier A. "Ovarian Venous Sampling Supports the Diagnosis of a Rare Virilizing Tumor in a Pediatric Patient." Poster at *Pediatric Endocrine Society Annual Meeting*, April 2020 (meeting canceled).
13. **Bruggeman BS**, Campbell-Thompson MA, Posgai AL, Atkinson MA, Schatz D, Jacobsen LM. "Effect of Substance Use on Type 1 Diabetes Pancreas Histopathology." Poster at *American Diabetes Association Annual Meeting*, June 2019. https://doi.org/10.2337/db19-1366-P
14. **Bruggeman BS,** Vincent HK, Chi X, Filipp SL, Mercado R, Modave F, Guo Y, Gurka MJ, Bernier A. "Simple Tests of Cardiorespiratory Fitness in a Pediatric Population: A Feasibility Study." Poster at *Pediatric Academic Society Annual Meeting*, April 2019.
15. **Bruggeman B**, Dayton K. "An Unusual Presentation of Pseudohypoparathyroidism Type 1a Associated with a Novel GNAS Mutation and Vitamin D Deficiency." Guided Presidential Poster Session at *Endocrine Society Annual Meeting*, March 2019. https://doi.org/10.1210/js.2019-MON-252
16. Morris HL, Donahoo WT, **Bruggeman B**, Zimmerman C, Hiers P, Zhong VW, Schatz D. "Development of a Computable Phenotype for Youth with Type 1 Diabetes." Poster at *American Public Health Association Annual Meeting,* Nov. 2018.
17. Walker AF, Haller MJ, Gurka MJ, Morris HL, Anez-Zabala C, **Bruggeman BS**, Guiffre D, Rohrs H, Atkinson MA, Schatz D. "Promoting Health Equity in Type 1 Diabetes through Peer Mentorship- Findings from the All for ONE Randomized Controlled Trial." Moderated Poster Discussion at *American Diabetes Association Annual Meeting*, June 2018. https://doi.org/10.2337/db18-1371-P

18. Walker AF, Johnson C, Anez-Zabala C, Dorvil SR, Haller MJ, Gurka MJ, **Bruggeman BS**, Guiffre D, Atkinson MA, Schatz I, Schatz D. "A Content Analysis of Text Messages in a Type 1 Diabetes Peer Mentoring Program-The Importance of Shared Interests." Poster at *American Diabetes Association Annual Meeting*, June 2018. https://doi.org/10.2337/db18-844-P

19. Zimmerman C, **Bruggeman B,** LaPorte A, Kaushal S, Stalvey M, Beauchamp G, Dayton K, Hiers P, Filipp SL, Gurka MJ, Silverstein JH, Jacobsen LJ. "Prevalence and Characterization of Retinopathy in Children with Type 1 Diabetes Using a Non-mydriatic Fundus Camera." Poster at *American Diabetes Association Annual Meeting*, Aug. 2017.

20. **Sorensen B**, Silverstein J. "Comparison of effectiveness of Glulisine, Lispro, and Aspart in decreasing post-prandial hyperglycemia in a real-world setting." Poster at *Pediatric Academic Societies Annual Meeting*, May 2013.

Regional Presentations

1. Gornisiewicz S, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D, **Bruggeman BS**. "Serum Exocrine Enzymes as Biomarkers of Response to Immunotherapy in Type 1 Diabetes." Poster at *FCAAP 8th Annual Pediatric Research Forum for Medical Students,* September 2022.

2. **Bruggeman B,** Zimmerman C, LaPorte A, Kaushal S, Stalvey M, Beauchamp G, Dayton K, Hiers P, Filipp SL, Gurka MJ, Silverstein JH, Jacobsen LJ. "Prevalence and Characterization of Retinopathy in Children with Type 1 Diabetes Using a Non-mydriatic Fundus Camera." Poster at *Children with Diabetes Friends for Life Conference*, July 2018.

3. **Bruggeman B,** Zimmerman C, LaPorte A, Kaushal S, Stalvey M, Beauchamp G, Dayton K, Hiers P, Filipp SL, Gurka MJ, Silverstein JH, Jacobsen LJ. "Prevalence and Characterization of Retinopathy in Children with Type 1 Diabetes Using a Non-mydriatic Fundus Camera." Poster at *Florida Medical Association David A. Paulus, MD Poster Symposium*, Aug. 2017.

4. **Bruggeman B.** "Comparison of effectiveness of Glulisine, Lispro, and Aspart in decreasing post-prandial hyperglycemia in a real-world setting." Oral presentation at *FCAAP Pediatric Medical Student Research Forum*, Aug. 2014.

5. **Sorensen B**, Simpson N. "Developing methods to optimize efficacy of a bioartificial pancreas as a therapy for type 1 diabetes in a C3H/HeN mouse model." Poster at *Furman Engaged Research Symposium*, April 2011.

6. **Sorensen B**, Simpson N. "Developing methods to optimize efficacy of a bioartificial pancreas as a therapy for type 1 diabetes in a C3H/HeN mouse model." Poster at *Florida Statewide Student Research Symposium*, March 2011.

Local Presentations

1. Guyot M, Williams M, Bumgarner BM, Brusko M, Campbell-Thompson M, Wasserfall C, **Bruggeman B**. "The development of a MACSima imaging cyclic staining (MICS) panel to evaluate exocrine pancreatic pathology in type 1 diabetes (T1D)." Poster at *2023 Spring Undergraduate Research Symposium*, April 2023.
2. Guyot M, Williams M, Bumgarner BM, Brusko M, Campbell-Thompson M, Wasserfall C, **Bruggeman B**. "The development of a MACSima imaging cyclic staining (MICS) panel to evaluate exocrine pancreatic pathology in type 1 diabetes (T1D)." Poster at *STEM at UF Research Symposium*, March 2023.
3. Guyot M, Williams M, Bumgarner BM, Brusko M, Campbell-Thompson M, Wasserfall C, **Bruggeman B**. "The development of a MACSima imaging cyclic staining (MICS) panel to evaluate exocrine pancreatic pathology in type 1 diabetes (T1D)." Poster at *13th annual UF College of Medicine Celebration of Research*, February 2023.
4. Sarcone C, Turk L, Jacobsen L, Campbell-Thompson M, **Bruggeman B**. "Chronic Pancreatitis and Acinar Atrophy by Histopathology Characterize Young nPOD Donors with Reduced Pancreas Organ Weight and May Precede this Finding in the Progression to Type 1 Diabetes." Poster at *13th annual UF College of Medicine Celebration of Research*, February 2023.
5. Gornisiewicz S, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D, **Bruggeman BS**. "Serum Exocrine Enzymes as Biomarkers of Response to Immunotherapy in Type 1 Diabetes." Poster at *13th annual UF College of Medicine Celebration of Research*, February 2023.
6. **Bruggeman BS.** "Exocrine Pancreas Pathology in Type 1 Diabetes." Oral Presentation at *UF Pediatrics Fellows Research Conference*, January 2021.
7. **Bruggeman BS.** "Exocrine Pancreas Pathology in Type 1 Diabetes." Oral Presentation at *UF Pediatrics Fellows Research Conference*, May 2020.
8. **Bruggeman BS**, Campbell-Thompson MA, Posgai AL, Atkinson MA, Schatz D, Jacobsen LM. "Effect of Substance Use on Type 1 Diabetes Pancreas Histopathology." Poster at *UF Diabetes Institute World Diabetes Day Poster Session*, Nov. 2019.

9. **Bruggeman BS**. "Simple Tests of Cardiorespiratory Fitness in a Pediatric Population: A Feasibility Study." Oral Presentation at *UF Pediatric Science Day*, June 2019.
10. **Bruggeman BS**, Campbell-Thompson MA, Posgai AL, Atkinson MA, Schatz D, Jacobsen LM. "Effect of Substance Use on Type 1 Diabetes Pancreas Histopathology." Poster at *UF Pediatric Science Day*, June 2019.
11. Zimmerman C, Morris HL, Donahoo WT, **Bruggeman B**, Hiers P, Zhong VW, Schatz D. "Development of a Computable Phenotype for Youth with Type 1 Diabetes." Poster at *UF Pediatric Science Day,* June 2018.
12. **Bruggeman B**, Guiffre D, Walker A. "Improving Type 1 Diabetes Compliance Using a Mentorship Program." Poster at *UF Health Pediatric Residency Quality Improvement Symposium*, Aug. 2017.
13. **Bruggeman B,** Zimmerman C, LaPorte A, Kaushal S, Stalvey M, Beauchamp G, Dayton K, Hiers P, Filipp SL, Gurka MJ, Silverstein JH, Jacobsen LJ. "Prevalence and Characterization of Retinopathy in Children with Type 1 Diabetes Using a Non-mydriatic Fundus Camera." Poster at *UF Pediatric Science Day*, May 2017.
14. **Bruggeman BS**, Zimmerman C. "Prevalence and Characterization of Retinopathy in Children with Type 1 Diabetes Using a Non-mydriatic Fundus Camera." Oral Presentation at *UF Pediatrics Fellows Research Conference*, Nov. 2016.
15. **Sorensen B**, Silverstein J. "Comparison of effectiveness of Glulisine, Lispro, and Aspart in decreasing post-prandial hyperglycemia in a real-world setting." Poster at *University of Florida Medical Student Research Day*, April 2013.
16. **Sorensen B**, Simpson N. "Developing methods to optimize efficacy of a bioartificial pancreas as a therapy for type 1 diabetes in a C3H/HeN mouse model." Poster at *Junior Honors Medical Program Research Symposium*, April 2011.
17. **Sorensen B**, Simpson N. "Developing methods to optimize efficacy of a bioartificial pancreas as a therapy for type 1 diabetes in a C3H/HeN mouse model." Poster at *HHMI Creativity in the Arts and Sciences Event*, Jan. 2011.

Ongoing Research Support

NIH NIDDK K23 Career Development Award
Role: Mentored PI January 2023-November 2026
Title: "Natural History and Mechanisms of Exocrine Pancreatic Dysfunction in Pre-Type 1 Diabetes."

This project aims to investigate the natural history and role of exocrine loss in pre-T1D while cultivating the skills and experience necessary to establish an independent career as a physician scientist in T1D clinical and translational research.

Georgia Center for Diabetes Translation Research 2022 Pilot and Feasibility Program Cycle

Role: PI February 2023-January 2024

Title: "A Provider-Facing EHR-Based Dashboard to Improve Health Equity in Type 1 Diabetes."

This project aims to conceptualize and create capacity for a T1D Technology Health Equity Dashboard within the University of Florida and Emory University Health systems.

NIH NIDDK Extramural Loan Repayment Program for Pediatric Research

Role: Mentored PI July 2022-June 2024

Title: "Natural History and Mechanisms of Exocrine Pancreatic Dysfunction in Pre-Type 1 Diabetes."

This project aims to investigate the natural history of exocrine loss in T1D by measuring fecal elastase throughout the course of pre-T1D and to investigate exocrine autoimmunity as a potential mechanism for exocrine dysfunction in T1D while cultivating the skills and experience necessary to establish an independent career as a physician scientist in T1D clinical and translational research.

NIH NIDDK R03: New Investigator Gateway Awards for Collaborative T1D Research

Role: PI September 2021-August 2023

Title: "Natural History and Mechanisms of Exocrine Dysfunction in Pre-Type 1 Diabetes."

This project aims to investigate the natural history of exocrine loss in T1D by measuring fecal elastase throughout the course of pre-T1D within two different cohorts: The Environmental Determinants of Diabetes in the Young (TEDDY) study and a T1D TrialNet prospective ancillary study.

Pediatric Endocrine Society Clinical Scholar Award

Role: Mentored PI July 2021-June 2023

Title: "Natural History and Mechanisms of Exocrine Dysfunction in Pre-Type 1 Diabetes."

This project aims to investigate the natural history of exocrine loss in T1D by measuring fecal elastase throughout the course of pre-T1D and to investigate exocrine autoimmunity as a potential mechanism for exocrine dysfunction in T1D.

Completed Grants

University of Florida Clinical and Translational Research Institute KL2 Career Development Award
Role: Mentored PI July 2021-June 2023
Title: "Natural History and Mechanisms of Exocrine Dysfunction in Pre-Type 1 Diabetes."
This project aims to investigate the natural history of exocrine loss in T1D by measuring fecal elastase throughout the course of pre-T1D and to investigate exocrine autoimmunity as a potential mechanism for exocrine dysfunction in T1D while cultivating the skills and experience necessary to establish an independent career as a physician scientist in T1D clinical and translational research.

UF Medical Student Research Program Grant June 2011-July 2011
Role: Mentored PI
Title: "Comparison of Effectiveness of Glulisine, Lispro, and Aspart in decreasing post-prandial hyperglycemia in a real-world setting."
This project was a randomized, open-label trial that aimed to compare the glycemic excursion following food intake and post-meal injection of Apidra, Humalog, and Novolog insulins in a diabetes camp for children.

American Academy of Pediatrics Community Access to Child Health (CATCH) Resident Grant June 2018-August 2019
Role: Mentored co-PI
Title: "Health Smiles Day Initiative."
This project trained pediatric residents in oral health exams and provide free basic dental care, education, and referrals in an underserved area of Gainesville on an annual to biannual basis.

UF Children's Miracle Network Fellow Grant June 2018-June 2019
Role: Mentored co-PI
Title: "Fundal Photography as a Screening Tool for Diabetic Retinopathy in Pediatric Type 2 Diabetes."
This project aimed to assess the feasibility of screening for retinopathy in the pediatric type 2 diabetes patient population using a non-mydriatic fundus camera.

Inaugural McJunkin Family Type 1 Diabetes Fellow July 2018-July 2019
Role: PI
Awarded to fellows committed to careers as clinician-scientists in type 1 diabetes. Funds one year of pediatric endocrinology fellowship.

UF Children's Miracle Network Fellow Grant June 2019-June 2020
Role: Mentored PI

Title: "Mechanisms of Exocrine Dysfunction in Type 1 Diabetes."
This project aims to elucidate the relationship between AUC C-peptide, markers of immune function, and serum markers of exocrine pancreatic function in subjects enrolled in the clinical trial: "Antithymocyte Globulin (ATG) and pegylated granulocyte colony stimulating factor (GCSF) in New Onset Type 1 Diabetes."

Pediatric Endocrine Society Rising Star Award Jan. 2019-March 2021
Role: Mentored PI
Title: "Mechanisms of Exocrine Dysfunction in Type 1 Diabetes."
This project aims to elucidate the relationship between AUC C-peptide, markers of immune function, and serum markers of exocrine pancreatic function in subjects enrolled in the clinical trial: "Antithymocyte Globulin (ATG) and pegylated granulocyte colony stimulating factor (GCSF) in New Onset Type 1 Diabetes."

University of Florida Clinical and Translational Research Institute Pilot Award July 2019-June 2021
Role: Mentored PI
Title: "Mechanisms of Exocrine Dysfunction in Type 1 Diabetes."
This project aims to elucidate the relationship between AUC C-peptide, markers of immune function, and serum markers of exocrine pancreatic function in subjects enrolled in the clinical trial: "Antithymocyte Globulin (ATG) and pegylated granulocyte colony stimulating factor (GCSF) in New Onset Type 1 Diabetes."

Douglas J. Barrett, MD Academic Fellowship Award June 2020-June 2021
Role: PI
Title: "Mechanisms of Exocrine Dysfunction in Type 1 Diabetes."
Awarded to one fellow per year for highest qualities of scholarly activity in research, teaching, and patient care. Funds one year of pediatric endocrinology fellowship.

Endocrine Fellows Foundation Research Grant Jan. 2019-Dec. 2021
Role: Mentored PI
Title: "Mechanisms of Exocrine Dysfunction in Type 1 Diabetes."
This project aims to elucidate the relationship between AUC C-peptide, markers of immune function, and serum markers of exocrine pancreatic function in subjects enrolled in the clinical trial: "Antithymocyte Globulin (ATG) and pegylated granulocyte colony stimulating factor (GCSF) in New Onset Type 1 Diabetes."

Exhibit B

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