

No. 23-12159

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

Jane Doe et al.,
Plaintiffs-Appellees,

v.

Surgeon General, State of Florida et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:23-cv-114
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME I OF XIII

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Dated: September 13, 2023

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CIVIL DOCKET FOR CASE #: 4:23-cv-00114-RH-MAF

DOE et al v. LADAPO et al
Assigned to: JUDGE ROBERT L HINKLE
Referred to: MAGISTRATE JUDGE MARTIN A FITZPATRICK
Case in other court: USCA, 23-12159
Cause: 42:1983 Civil Rights Act

Date Filed: 03/23/2023
Jury Demand: None
Nature of Suit: 440 Civil Rights: Other
Jurisdiction: Federal Question

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Defendant

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USCA11 Case: 23-12159 Document: 34-1 Date Filed: 06/13/2025 Page: 28 of 249
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Defendant

ASHLEY MOODY
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TERMINATED: 06/22/2023*

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TERMINATED: 06/22/2023*

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TERMINATED: 06/22/2023

USCA11 Case: 23-12159 Document: 34-1 Date Filed: 09/13/2023 Page: 30 of 249
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Defendant

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CIRCUIT OF FLORIDA

TERMINATED: 06/22/2023

Defendant

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D JEAN VETA

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WILLIAM R ISASI

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AMERICAN PEDIATRIC SOCIETY

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**ASSOCIATION OF AMERICAN MEDICAL
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**ASSOCIATION OF MEDICAL SCHOOL
PEDIATRIC DEPARTMENT CHAIRS INC**

represented by **CORTLIN HALL LANNIN**
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ENDOCRINE SOCIETY

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**FLORIDA CHAPTER OF THE AMERICAN
ACADEMY OF PEDIATRICS**

represented by **CORTLIN HALL LANNIN**
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**NATIONAL ASSOCIATION OF PEDIATRIC
NURSE PRACTITIONERS**

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PEDIATRIC ENDOCRINE SOCIETY

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**SOCIETY FOR ADOLESCENT HEALTH
AND MEDICINE**

represented by **CORTLIN HALL LANNIN**

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EMILY MICHELLE MONDRY

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SOCIETY FOR PEDIATRIC RESEARCH

represented by **CORTLIN HALL LANNIN**

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ATTORNEY TO BE NOTICED

EMILY MICHELLE MONDRY

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*ATTORNEY TO BE NOTICED***Amicus****SOCIETY OF PEDIATRIC NURSES**represented by **CORTLIN HALL LANNIN**
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*ATTORNEY TO BE NOTICED***D JEAN VETA**

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*ATTORNEY TO BE NOTICED***EMILY MICHELLE MONDRY**

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*ATTORNEY TO BE NOTICED***NOAH SHEA GOLDBERG**

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*ATTORNEY TO BE NOTICED***WILLIAM R ISASI**

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*ATTORNEY TO BE NOTICED***Amicus****WORLD PROFESSIONAL ASSOCIATION
FOR TRANSGENDER HEALTH**represented by **CORTLIN HALL LANNIN**
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*ATTORNEY TO BE NOTICED***D JEAN VETA**

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*ATTORNEY TO BE NOTICED***EMILY MICHELLE MONDRY**

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*ATTORNEY TO BE NOTICED***NOAH SHEA GOLDBERG**

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*ATTORNEY TO BE NOTICED***WILLIAM R ISASI**

(See above for address)

ATTORNEY TO BE NOTICED

Date Filed	#	Docket Text
03/23/2023	<u>1</u>	COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF PRELIMINARY STATEMENT. (Filing fee \$ 402 receipt number AFLNDC-7783100.), filed by Fiona Foe, SUSAN DOE, JANE DOE, Christina Coe, Brenda Boe, Freya Foe, Bennett Boe, Carla Coe. (Attachments: # <u>1</u> Civil Cover Sheet) (SILVERMAN, LAWRENCE) Modified to edit title on 3/24/2023 (rcb). (Entered: 03/23/2023)
03/24/2023	2	DOCKET ANNOTATION BY COURT: Re <u>1</u> Complaint.**Party names (including aliases) are to be added using all caps and no punctuation. (See "Style Guide for Electronic Case Filing," available on Clerk's website.) The party names will be corrected by the clerk. Further, counsel is advised by this entry, that a Civil Cover Sheet must be filed as a separate entry using the event selection "Civil Cover

		Sheet" which is found under "Other Filings" under "Other Documents". PLEASE RE-FILE THE CIVIL COVER SHEET.** (rcb) (Entered: 03/24/2023)
03/24/2023		USCA11 Case: 23-12159 Document: 34-1 Date Filed: 09/13/2023 Page: 41 of 249 Set Deadline-Attorney Admissions for Kelly Jo Popkin, Sara Mandelbaum, Jennifer Levi, Chris Erchull,Jason Starr & Ami Patel due by 4/7/2023 . (rcb)**Attorney Admissions Email & Letter Forwarded** (Entered: 03/24/2023)
03/24/2023	<u>3</u>	CIVIL COVER SHEET. (SILVERMAN, LAWRENCE) (Entered: 03/24/2023)
03/24/2023	<u>4</u>	NOTICE <i>Plaintiffs' Notice of Filing Summonses</i> by Bennett Boe, Brenda Boe, Carla Coe, Christina Coe, JANE DOE, SUSAN DOE, Fiona Foe, Freya Foe re <u>1</u> Complaint, (Attachments: # <u>1</u> Summons, # <u>2</u> Summons, # <u>3</u> Summons, # <u>4</u> Summons, # <u>5</u> Summons, # <u>6</u> Summons, # <u>7</u> Summons, # <u>8</u> Summons, # <u>9</u> Summons, # <u>10</u> Summons, # <u>11</u> Summons, # <u>12</u> Summons, # <u>13</u> Summons, # <u>14</u> Summons, # <u>15</u> Summons, # <u>16</u> Summons, # <u>17</u> Summons, # <u>18</u> Summons, # <u>19</u> Summons, # <u>20</u> Summons, # <u>21</u> Summons, # <u>22</u> Summons, # <u>23</u> Summons, # <u>24</u> Summons, # <u>25</u> Summons) (SILVERMAN, LAWRENCE) (Entered: 03/24/2023)
03/24/2023	<u>5</u>	NOTICE <i>Plaintiffs' Notice of Similar Case</i> by Bennett Boe, Brenda Boe, Carla Coe, Christina Coe, JANE DOE, SUSAN DOE, Fiona Foe, Freya Foe (SILVERMAN, LAWRENCE) (Entered: 03/24/2023)
03/27/2023	<u>6</u>	Summons Issued as to SCOT ACKERMAN, Wael Barsoum, Matthew R. Benson, Gregory Coffman, Chris Creegan, Amy Derick, David Diamond, Watson Ducatel, FLORIDA BOARD OF MEDICINE, MARIA GARCIA, Patrick Hunter, Valerie Jackson, Nicole Justice, William D. Kirsh, Joseph A. Ladapo, Monica M. Mortensen, Luz Marina Pages, Eleonor Pimentel, Nicholas W. Romanello, Tiffany Sizemore Di Pietro, Hector Vila, GREGORY WILLIAMS. (Attachments: # <u>1</u> Florida Board of Osteopathic Medicine c/o William D. Kirsh, Member of the Florida Board of Osteopathic Medicine, # <u>2</u> Florida Board of Osteopathic Medicine c/o Watson Ducatel, Member of the Florida Board of Osteopathic Medicine, # <u>3</u> Florida Board of Medicine c/o Patrick Hunter, Member of the Florida Board of Medicine, # <u>4</u> Florida Board of Medicine c/o Nicole Justice, Member of the Florida Board of Medicine, # <u>5</u> Florida Board of Medicine c/o David Diamond, Member of the Florida Board of Medicine, # <u>6</u> Florida Board of Medicine c/o Amy Derick, Member of the Florida Board of Medicine, # <u>7</u> Florida Board of Osteopathic Medicine c/o Chris Creegan, Member of the Florida Board of Osteopathic Medicine, # <u>8</u> Florida Board of Medicine c/o Wael Barsoum, Member of the Florida Board of Medicine, # <u>9</u> Florida Board of Osteopathic Medicine c/o Valerie Jackson, Member of the Florida Board of Osteopathic Medicine, # <u>10</u> Florida Board of Osteopathic Medicine c/o Tiffany Sizemore Di Pietro, Chair, # <u>11</u> Florida Board of Medicine c/o Scot Ackerman, Chair, # <u>12</u> Florida Board of Osteopathic Medicine c/o Monica M. Mortensen, Member of the Florida Board of Osteopathic Medicine, # <u>13</u> Florida Board of Medicine c/o Hector Vila, Member of the Florida Board of Medicine, # <u>14</u> Florida Board of Osteopathic Medicine c/o Gregory Williams, Member of the Florida Board of Osteopathic Medicine, # <u>15</u> Florida Board of Medicine c/o Nicole Justice, Member of the Florida Board of Medicine, # <u>16</u> Florida Board of Medicine c/o Nicholas W. Romanello, Member of the Florida Board of Medicine, # <u>17</u> Florida Board of Medicine c/o Matthew R. Benson, Member of the Florida Board of Medicine, # <u>18</u> Florida Board of Medicine c/o Maria Garcia, Member of the Florida Board of Medicine, # <u>19</u> Florida Board of Medicine c/o Gregory Coffman, Member of the Florida Board of Medicine) (rcb) # <u>20</u> Florida Board of Medicine Michael Wasylik , # <u>21</u> Florida Board of Medicine Zachariah Zachariah (rcb). (Attachment 20 replaced on 3/27/2023) (rcb). (Entered: 03/27/2023)
03/27/2023	<u>7</u>	Summons Issued as to MEDICINE, ELEONOR PIMENTEL. # <u>1</u> FLORIDA BOARD OF MEDICINE, # <u>2</u> FLORIDA BOARD OF OSTEOPATHIC MEDICINE (rcb) (Entered: 03/27/2023)
03/30/2023	<u>8</u>	MOTION to Appear Pro Hac Vice by Chris Erchull.(Filing fee \$ 208 receipt number AFLNDC-7794105.) by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE. (ERCHULL, CHRISTOPHER) (Entered: 03/30/2023)
03/31/2023	<u>9</u>	MOTION to Appear Pro Hac Vice by Jennifer Levi.(Filing fee \$ 208 receipt number AFLNDC-7794606.) by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE. (LEVI, JENNIFER) (Entered: 03/31/2023)
03/31/2023		ACTION REQUIRED BY MAGISTRATE JUDGE: Chambers of MAGISTRATE JUDGE MARTIN A FITZPATRICK notified that action is needed Re: <u>9</u> MOTION to Appear Pro Hac Vice by Jennifer

		Levi.(Filing fee \$ 208 receipt number AFLNDC-7794606.), 8 MOTION to Appear Pro Hac Vice by Chris Erchull.(Filing fee \$ 208 receipt number AFLNDC-7794105.). Referred to MARTIN A FITZPATRICK. (rcb) (Entered: 03/31/2023)
		USCA11 Case: 23-1159 Document: 0334-1 Date Filed: 09/13/2023 Page: 42 of 249
04/04/2023	10	MOTION to Appear Pro Hac Vice by Ami Rakesh Patel.(Filing fee \$ 208 receipt number BFLNDC-7801367.) by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE. (PATEL, AMI) (Entered: 04/04/2023)
04/04/2023	11	ORDER. Accordingly, it is ORDERED that the motion for leave to appear pro hac vice, ECF No. 8 , is GRANTED. Signed by MAGISTRATE JUDGE MARTIN A FITZPATRICK on 04/04/2023. (rcb) (Entered: 04/04/2023)
04/04/2023	12	ORDER. Accordingly, it is ORDERED that the motion for leave to appear pro hac vice, ECF No. 9 , is GRANTED. Signed by MAGISTRATE JUDGE MARTIN A FITZPATRICK on 04/04/2023. (rcb) (Entered: 04/04/2023)
04/04/2023	13	MOTION to Appear Pro Hac Vice by Sara L. Mandelbaum.(Filing fee \$ 208 receipt number AFLNDC-7802113.) by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE. (MANDELBAUM, SARA) (Entered: 04/04/2023)
04/04/2023	14	CORRECTED ORDER. Accordingly, it is ORDERED that the motion for leave to appear pro hac vice, ECF No. 8 , is GRANTED. Signed by MAGISTRATE JUDGE MARTIN A FITZPATRICK on 4/04/2023. (rcb) Modified on 4/6/2023 (rcb). (Entered: 04/05/2023)
04/04/2023	15	CORRECTED ORDER. Accordingly, it is ORDERED that the motion for leave to appear pro hac vice, ECF No. 9 , is GRANTED. Signed by MAGISTRATE JUDGE MARTIN A FITZPATRICK on 04/04/2023. (rcb) Modified on 4/6/2023 (rcb). (Entered: 04/05/2023)
04/05/2023		ACTION REQUIRED BY MAGISTRATE JUDGE: Chambers of MAGISTRATE JUDGE MARTIN A FITZPATRICK notified that action is needed Re: 10 MOTION to Appear Pro Hac Vice by Ami Rakesh Patel.(Filing fee \$ 208 receipt number BFLNDC-7801367.), 13 MOTION to Appear Pro Hac Vice by Sara L. Mandelbaum.(Filing fee \$ 208 receipt number AFLNDC-7802113.). Referred to MARTIN A FITZPATRICK. (rcb) (Entered: 04/05/2023)
04/06/2023	16	MOTION FOR LEAVE TO APPEAR PRO HAC VICE.(Filing fee \$ 208 receipt number AFLNDC-7806963.) by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE. (Attachments: # 1 Exhibit Certificate of Good Standing) (POPKIN, KELLY) Modified to edit title on 4/6/2023 (rcb). (Entered: 04/06/2023)
04/06/2023		ACTION REQUIRED BY MAGISTRATE JUDGE: Chambers of JUDGE ROBERT L HINKLE notified that action is needed Re: 16 MOTION to Appear Pro Hac Vice by Kelly Jo Popkin.(Filing fee \$ 208 receipt number AFLNDC-7806963.). Referred to MARTIN A FITZPATRICK. (rcb) (Entered: 04/06/2023)
04/06/2023		ACTION REQUIRED BY MAGISTRATE JUDGE: Chambers of MAGISTRATE JUDGE MARTIN A FITZPATRICK notified that action is needed. ***Incorrect Referral Made to District Judge**. Re: 16 MOTION to Appear Pro Hac Vice by Kelly Jo Popkin. Filing fee \$ 208 receipt number AFLNDC-7806963. Referred to MARTIN A FITZPATRICK. (rcb) (Entered: 04/06/2023)
04/06/2023	17	MOTION to Amend/Correct 16 MOTION to Appear Pro Hac Vice by Kelly Jo Popkin.(Filing fee \$ 208 receipt number AFLNDC-7806963.) by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE. (POPKIN, KELLY) (Entered: 04/06/2023)
04/06/2023	18	MOTION to Appear Pro Hac Vice(Filing fee \$ 208 receipt number CFLNDC-7807078.) by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE. (Attachments: # 1 Appendix Certificate of Good Standing) (STARR, JASON) (Entered: 04/06/2023)
04/06/2023	19	MOTION PROCEED UNDER PSEUDONYM by BENNETT BOE, BRENDA BOE. (SILVERMAN, LAWRENCE) (Entered: 04/06/2023)
04/06/2023	20	MOTION PROCEED UNDER PSEUDONYM by CARLA COE, CHRISTINA COE.

(SILVERMAN, LAWRENCE) (Entered: 04/06/2023)

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04/06/2023	<u>21</u>	MOTION PROCEED UNDER PSEUDONYM by JANE DOE, SUSAN DOE. (SILVERMAN, LAWRENCE) (Entered: 04/06/2023)
04/06/2023	<u>22</u>	MOTION PROCEED UNDER PSEUDONYM by FIONA FOE, FREYA FOE. (SILVERMAN, LAWRENCE) (Entered: 04/06/2023)
04/07/2023		ACTION REQUIRED BY MAGISTRATE JUDGE: Chambers of MAGISTRATE JUDGE MARTIN A FITZPATRICK notified that action is needed Re: <u>18</u> MOTION to Appear Pro Hac Vice(Filing fee \$ 208 receipt number CFLNDC-7807078.), <u>17</u> MOTION to Amend/Correct <u>16</u> MOTION to Appear Pro Hac Vice by Kelly Jo Popkin.(Filing fee \$ 208 receipt number AFLNDC-7806963.) . Referred to MARTIN A FITZPATRICK. (rcb) (Entered: 04/07/2023)
04/07/2023		Set/Reset Deadlines as to <u>20</u> MOTION PROCEED UNDER PSEUDONYM , <u>19</u> MOTION PROCEED UNDER PSEUDONYM , <u>22</u> MOTION PROCEED UNDER PSEUDONYM , <u>21</u> MOTION PROCEED UNDER PSEUDONYM . (Internal deadline for referral to judge if response not filed earlier: 4/21/2023). (rcb) (Entered: 04/07/2023)
04/07/2023	<u>23</u>	ORDER. Accordingly, it is ORDERED that the motion for leave to appear pro hac vice, ECF No. <u>13</u> , is GRANTED. Signed by MAGISTRATE JUDGE MARTIN A FITZPATRICK on 04/07/2023. (rcb) (Entered: 04/07/2023)
04/07/2023	<u>24</u>	ORDER. The amended motion for leave to appear pro hac vice, ECF No. <u>17</u> , is GRANTED.The first motion for leave to appear pro hac vice, ECF No. <u>16</u> , isDENIED as moot. Signed by MAGISTRATE JUDGE MARTIN A FITZPATRICK on 04/07/2023. (rcb) (Entered: 04/07/2023)
04/07/2023	<u>25</u>	ORDER. Accordingly, it is ORDERED that the motion for leave to appear pro hac vice, ECF No. <u>18</u> , is GRANTED. Signed by MAGISTRATE JUDGE MARTIN A FITZPATRICK on 04/07/2023. (rcb) (Entered: 04/07/2023)
04/10/2023	<u>26</u>	ORDER. Accordingly, it is ORDERED that the motion for leave to appear pro hac vice, ECF No. <u>10</u> , is GRANTED. Signed by MAGISTRATE JUDGE MARTIN A FITZPATRICK on 04/10/2023. (rcb) (Entered: 04/10/2023)
04/13/2023	<u>27</u>	Summons Issued as to LUZ MARINA PAGES MEMBER OF THE FLORIDA BOARD OF MEDICINE,. Attachments: # <u>1</u> SUMMONS ISSUED-MICHAEL WASYLIK MEMBER OF THE FLORIDA BOARD OF MEDICINE) (rcb) (Entered: 04/13/2023)
04/18/2023	<u>28</u>	WAIVER OF SERVICE Returned Executed by All DEFENDANTS. (PERAL, STEPHANIE) Modified to edit title on 4/19/2023 (rcb). (Entered: 04/18/2023)
04/19/2023		Set Deadline- ANSWER DUE FOR IONA FOE, SUSAN DOE, JANE DOE, CHRISTINA COE, BRENDA BOE, FREYA FOE, BENNETT BOE, CARLA COE by 6/12/2023 . (rcb) (Entered: 04/19/2023)
04/24/2023	<u>29</u>	FIRST AMENDED COMPLAINT against SCOT ACKERMAN, Wael Barsoum, Matthew R Benson, Gregory Coffman, Chris Creegan, Amy Derick, David Diamond, Watson Ducatel, Florida Board of Medicine, Florida Board of Osteopathic Medicine, Maria Garcia, Patrick Hunter, Valerie Jackson, Nicole Justice, William D Kirsh, Joseph A Ladapo, Monica M Mortensen, Luz Marina Pages, Eleonor Pimentel, Nicholas W Romanello, Tiffany Sizemore Di Pietro, Hector Vila, Michael Wasylik, Gregory Williams, Zachariah P Zachariah, filed by FIONA FOE, SUSAN DOE, JANE DOE, CHRISTINA COE, BRENDA BOE, FREYA FOE, BENNETT BOE, CARLA COE. (CHRISS, SIMONE) (Entered: 04/24/2023)
04/24/2023	<u>30</u>	MOTION for Preliminary Injunction by JANE DOE, SUSAN DOE, LINDA LOE, LISA LOE, GLORIA GOE, GAVIN GOE. (Attachments: # <u>1</u> Exhibit Declaration of Jane Doe, # <u>2</u> Exhibit Declaration of Linda Loe, # <u>3</u> Exhibit Declaration of Gloria Goe, # <u>4</u> Exhibit Declaration of Dr. Shumer, # <u>5</u> Exhibit Declaration of Dr. Janssen, # <u>6</u> Exhibit Declaration of Dr. Bruggeman) (CHRISS, SIMONE) (Entered: 04/24/2023)

04/24/2023	31	MOTION re 30 MOTION for Preliminary Injunction to <i>Proceed Under Pseudonym</i> by JANE DOE, SUSAN DOE. (CHRISS, SIMONE) (Entered: 04/24/2023)
04/24/2023	32	MOTION for Leave to Proceed Under Pseudonym by GAVIN GOE, GLORIA GOE. (CHRISS, SIMONE) (Entered: 04/24/2023)
04/24/2023	33	MOTION for Leave to Proceed Under Pseudonym by LINDA LOE, LISA LOE. (CHRISS, SIMONE) (Entered: 04/24/2023)
04/24/2023	34	MOTION for Leave to Proceed Under Pseudonym by PATRICIA POE, PAUL POE. (CHRISS, SIMONE) (Entered: 04/24/2023)
04/24/2023	35	NOTICE of Appearance by NOAH SHEA GOLDBERG on behalf of AMERICAN ACADEMY OF PEDIATRICS, ACADEMIC PEDIATRIC ASSOCIATION, American Academy of Child & Adolescent Psychiatry, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF NURSING, American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ Equality, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN MEDICAL ASSOCIATION, AMERICAN PEDIATRIC SOCIETY, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, Association of Medical School Pediatric Department Chairs, Inc., ENDOCRINE SOCIETY, FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, NATIONAL ASSOCIATION OF PEDIATRIC NURSE PRACTITIONERS, PEDIATRIC ENDOCRINE SOCIETY, SOCIETIES FOR PEDIATRIC UROLOGY, SOCIETY FOR ADOLESCENT HEALTH AND MEDICINE, SOCIETY FOR PEDIATRIC RESEARCH, SOCIETY OF PEDIATRIC NURSES, WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH (GOLDBERG, NOAH) (Entered: 04/24/2023)
04/24/2023	36	MOTION for Leave to File <i>Amici Curiae Brief in Support of Plaintiffs' Motion for Preliminary Injunction</i> by ACADEMIC PEDIATRIC ASSOCIATION, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF NURSING, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN MEDICAL ASSOCIATION, AMERICAN PEDIATRIC SOCIETY, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, American Academy of Child & Adolescent Psychiatry, American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ Equality, Association of Medical School Pediatric Department Chairs, Inc., ENDOCRINE SOCIETY, FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, NATIONAL ASSOCIATION OF PEDIATRIC NURSE PRACTITIONERS, PEDIATRIC ENDOCRINE SOCIETY, SOCIETIES FOR PEDIATRIC UROLOGY, SOCIETY FOR ADOLESCENT HEALTH AND MEDICINE, SOCIETY FOR PEDIATRIC RESEARCH, SOCIETY OF PEDIATRIC NURSES, WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH. (Attachments: # 1 Exhibit Proposed Amici Curiae Brief) (GOLDBERG, NOAH) (Entered: 04/24/2023)
04/25/2023		ACTION REQUIRED BY DISTRICT JUDGE: Chambers of JUDGE ROBERT L HINKLE notified that action is needed Re: 35 Notice of Appearance. (rcb)**An ISO is needed** (Entered: 04/25/2023)
04/25/2023	37	ORDER SETTING A SCHEDULING CONFERENCE (re 30 Motion for Preliminary Injunction) - By separate notice, the clerk must set a scheduling conference by telephone for 5/1/2023 at 1:00 PM . It will be moved to another date available on the court's calendar if all parties agree. The courtroom deputy clerk must cooperate with the parties on the availability of other dates. Signed by JUDGE ROBERT L HINKLE on 4/25/2023. (ckm) (Entered: 04/25/2023)
04/25/2023	38	NOTICE OF TELEPHONIC HEARING: Telephonic Scheduling Conference set for 5/1/2023 01:00 PM before JUDGE ROBERT L HINKLE. Call in number: 888-684-8852 Access code: 3243416# Security code: 1234#

04/25/2023	<u>39</u>	MOTION to Appear Pro Hac Vice(Filing fee \$ 208 receipt number AFLNDC-7839111.) by ACADEMIC PEDIATRIC ASSOCIATION, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF NURSING, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN MEDICAL ASSOCIATION, AMERICAN PEDIATRIC SOCIETY, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, American Academy of Child & Adolescent Psychiatry, American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ Equality, Association of Medical School Pediatric Department Chairs, Inc., ENDOCRINE SOCIETY, FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, NATIONAL ASSOCIATION OF PEDIATRIC NURSE PRACTITIONERS, PEDIATRIC ENDOCRINE SOCIETY, SOCIETIES FOR PEDIATRIC UROLOGY, SOCIETY FOR ADOLESCENT HEALTH AND MEDICINE, SOCIETY FOR PEDIATRIC RESEARCH, SOCIETY OF PEDIATRIC NURSES, WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH. (Attachments: # <u>1</u> Exhibit A - Certificate of Good Standing) (ISASI, WILLIAM) (Entered: 04/25/2023)
04/25/2023	<u>40</u>	MOTION to Appear Pro Hac Vice by Cortlin H. Lannin.(Filing fee \$ 208 receipt number AFLNDC-7839133.) by ACADEMIC PEDIATRIC ASSOCIATION, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF NURSING, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN MEDICAL ASSOCIATION, AMERICAN PEDIATRIC SOCIETY, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, American Academy of Child & Adolescent Psychiatry, American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ Equality, Association of Medical School Pediatric Department Chairs, Inc., ENDOCRINE SOCIETY, FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, NATIONAL ASSOCIATION OF PEDIATRIC NURSE PRACTITIONERS, PEDIATRIC ENDOCRINE SOCIETY, SOCIETIES FOR PEDIATRIC UROLOGY, SOCIETY FOR ADOLESCENT HEALTH AND MEDICINE, SOCIETY FOR PEDIATRIC RESEARCH, SOCIETY OF PEDIATRIC NURSES, WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH. (Attachments: # <u>1</u> Exhibit A - Certificate of Good Standing) (LANNIN, CORTLIN) (Entered: 04/25/2023)
04/25/2023	<u>41</u>	MOTION to Appear Pro Hac Vice by Emily M. Mondry.(Filing fee \$ 208 receipt number AFLNDC-7839144.) by ACADEMIC PEDIATRIC ASSOCIATION, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF NURSING, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN MEDICAL ASSOCIATION, AMERICAN PEDIATRIC SOCIETY, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, American Academy of Child & Adolescent Psychiatry, American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ Equality, Association of Medical School Pediatric Department Chairs, Inc., FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, NATIONAL ASSOCIATION OF PEDIATRIC NURSE PRACTITIONERS, PEDIATRIC ENDOCRINE SOCIETY, SOCIETIES FOR PEDIATRIC UROLOGY, SOCIETY FOR ADOLESCENT HEALTH AND MEDICINE, SOCIETY FOR PEDIATRIC RESEARCH, SOCIETY OF PEDIATRIC NURSES, WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH. (Attachments: # <u>1</u> Exhibit A - Certificate of Good Standing) (MONDRY, EMILY) (Entered: 04/25/2023)
04/25/2023	<u>42</u>	MOTION to Appear Pro Hac Vice by D. Jean Veta.(Filing fee \$ 208 receipt number AFLNDC-7839172.) by ACADEMIC PEDIATRIC ASSOCIATION, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF NURSING, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS,

USCA11 Case: 23-150 Date Filed: 05/12/2023 Page: 46 of 149		AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN MEDICAL ASSOCIATION, AMERICAN PEDIATRIC SOCIETY, ASSOCIATION OF AMERICAN MEDICAL NURSES, American Academy of Child & Adolescent Psychiatry, American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ Equality, Association of Medical School Pediatric Department Chairs, Inc., ENDOCRINE SOCIETY, FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, NATIONAL ASSOCIATION OF PEDIATRIC NURSE PRACTITIONERS, PEDIATRIC ENDOCRINE SOCIETY, SOCIETIES FOR PEDIATRIC UROLOGY, SOCIETY FOR ADOLESCENT HEALTH AND MEDICINE, SOCIETY FOR PEDIATRIC RESEARCH, SOCIETY OF PEDIATRIC NURSES, WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH. (Attachments: # 1 Exhibit A - Certificate of Good Standing) (VETA, D) (Entered: 04/25/2023)
04/25/2023	43	MOTION to Appear Pro Hac Vice by Cynthia Cheng-Wun Weaver.(Filing fee \$ 208 receipt number CFLNDC-7839815.) by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LINDA LOE, LISA LOE, PATRICIA POE, PAUL POE. (WEAVER, CYNTHIA) (Entered: 04/25/2023)
04/26/2023		ACTION REQUIRED BY MAGISTRATE JUDGE: Chambers of MAGISTRATE JUDGE MARTIN A FITZPATRICK notified that action is needed Re: 42 MOTION to Appear Pro Hac Vice by D. Jean Veta.(Filing fee \$ 208 receipt number AFLNDC-7839172.), 43 MOTION to Appear Pro Hac Vice by Cynthia Cheng-Wun Weaver.(Filing fee \$ 208 receipt number CFLNDC-7839815.), 40 MOTION to Appear Pro Hac Vice by Cortlin H. Lannin.(Filing fee \$ 208 receipt number AFLNDC-7839133.), 41 MOTION to Appear Pro Hac Vice by Emily M. Mondry.(Filing fee \$ 208 receipt number AFLNDC-7839144.), 39 MOTION to Appear Pro Hac Vice(Filing fee \$ 208 receipt number AFLNDC-7839111.). Referred to MARTIN A FITZPATRICK. (rcb) (Entered: 04/26/2023)
04/27/2023	44	ORDER. The motion for leave to appear pro hac vice, ECF No. 39 , is GRANTED. The motion for leave to appear pro hac vice, ECF No. 40 , is GRANTED. The motion for leave to appear pro hac vice, ECF No. 41 , is GRANTED. The motion for leave to appear pro hac vice, ECF No. 43 , is GRANTED. (Appointed D JEAN VETA, EMILY M. MONDRY, CORTLIN H. LANNIN, WILLIAM R. ISASI & CYNTHIA CHENG-WUN WEAVER). Signed by MAGISTRATE JUDGE MARTIN A FITZPATRICK on 4/27/2023. (rcb) Modified to edit Judge Association & Signature on 4/28/2023 (rcb). (Entered: 04/27/2023)
05/01/2023	45	NOTICE of Appearance by MOHAMMAD OMAR JAZIL on behalf of All Defendants (JAZIL, MOHAMMAD) (Entered: 05/01/2023)
05/01/2023	46	NOTICE of Appearance by MICHAEL ROBERT BEATO on behalf of All Defendants (BEATO, MICHAEL) (Entered: 05/01/2023)
05/01/2023	47	NOTICE of Appearance by GARY VERGIL PERKO on behalf of All Defendants (PERKO, GARY) (Entered: 05/01/2023)
05/01/2023	48	WAIVER OF SERVICE Returned Executed by FIONA FOE, LISA LOE, SUSAN DOE, JANE DOE, PAUL POE, GAVIN GOE, LINDA LOE, CHRISTINA COE, BRENDA BOE, FREYA FOE, BENNETT BOE, GLORIA GOE, PATRICIA POE, CARLA COE. All Defendants. (CHRISS, SIMONE) (Entered: 05/01/2023)
05/01/2023	49	Minute Entry for proceedings held before JUDGE ROBERT L HINKLE: Telephonic Scheduling Conference held on 5/1/2023 re: 30 motion for preliminary injunction. Ruling by Court: The motions to proceed under pseudonyms are granted. Defendants' response to motion for preliminary injunction is due by 5/15/2023 . An order will follow. (Court Reporter Megan Hague, Official Court Reporter) (ckm) (Entered: 05/01/2023)
05/02/2023		Set Deadline- Answer for due ALL DEFENDANTS RE: 48 by 6/23/2023 . (rcb) (Entered: 05/02/2023)
05/02/2023	51	ORDER ALLOWING USE OF PSEUDONYMS. The unopposed motions for leave to use pseudonyms, ECF Nos. 19 , 20 , 21 , 22 , 31 , 32 , 33 , and 34 , are granted. The plaintiffs may use

		pseudonyms as requested in the motions. Signed by JUDGE ROBERT L HINKLE on 05/02/2023. (rcb) (Entered: 05/03/2023)
05/02/2023	<u>52</u>	USCA11 Case: 23-12159 Document: 34-1 Date Filed: 09/13/2023 Page: 47 of 249 ORDER ALLOWING AMICUS BRIEF. The motion of American Academy of Pediatrics et al., ECF No. <u>36</u> , for leave to file an amicus brief in support of plaintiffs' motion for a preliminary injunction is granted. The amicus brief, ECF No. <u>36</u> -1, is deemed properly filed. Signed by JUDGE ROBERT L HINKLE on 05/02/2023. (rcb) (Entered: 05/03/2023)
05/03/2023	<u>50</u>	ORDER SETTING PRELIMINARY-INJUNCTION PROCEDURES.The deadline for the defendants to respond to the preliminary-injunction motion is extended to 5/15/2023 .The plaintiffs may file a reply memorandum in support of the motion by the later of (a) 5/17/2023 or (b) 24 hours before the oral argument. Signed by JUDGE ROBERT L HINKLE on 05/03/2023. (rcb) (Entered: 05/03/2023)
05/03/2023	<u>53</u>	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of telephonic Proceedings held on 5/1/2023, before Judge Robert L. Hinkle. Court Reporter/Transcriber Megan A. Hague, Telephone number 850-443-9797. <i>Transcript may be viewed at the court public terminal or purchased through the Court Reporter/Transcriber before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER.</i> Redaction Request due 5/10/2023 . Release of Transcript Restriction set for 8/8/2023 . (mah) (Entered: 05/03/2023)
05/11/2023	54	NOTICE OF HEARING on <u>30</u> Motion: Preliminary Injunction Hearing set for 5/19/2023 08:30 AM before JUDGE ROBERT L HINKLE, United States Courthouse, Courtroom 5 East, 111 North Adams St., Tallahassee, Florida 32301. NOTE: If you or any party, witness or attorney in this matter has a disability that requires special accommodation, such as a hearing impairment that requires a sign language interpreter or a wheelchair restriction that requires ramp access, please contact Cindy Markley at 850-521-3518 in the Clerk's Office at least one week prior to the hearing (or as soon as possible) so arrangements can be made. <i>s/ Cindy Markley</i> Courtroom Deputy Clerk (ckm) (Entered: 05/11/2023)
05/15/2023	<u>55</u>	THE STATE'S RESPONSE IN OPPOSITION TO PLAINTIFFS' PRELIMINARY-INJUNCTION MOTION. (JAZIL, MOHAMMAD) Modified to edit title on 5/16/2023 (rcb). (Entered: 05/15/2023)
05/17/2023	<u>56</u>	MOTION for Leave to File <i>Second Amended Complaint</i> by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LINDA LOE, LISA LOE, PATRICIA POE, PAUL POE. (Attachments: # <u>1</u> Exhibit Plaintiffs' Second Amended Complaint) (CHRISS, SIMONE) (Entered: 05/17/2023)
05/17/2023	<u>57</u>	MOTION for Temporary Restraining Order by JANE DOE, SUSAN DOE, GAVIN GOE, GLORIA GOE, LINDA LOE, LISA LOE. (Attachments: # <u>1</u> Text of Proposed Order - Temporary Restraining Order) (CHRISS, SIMONE) (Entered: 05/17/2023)
05/18/2023	<u>58</u>	REPLY to Response to Motion re <u>30</u> MOTION for Preliminary Injunction filed by JANE DOE, SUSAN DOE, GAVIN GOE, GLORIA GOE, LINDA LOE, LISA LOE. (Attachments: # <u>1</u> Exhibit Expert Declaration of Dr. Kenneth Goodman) (STARR, JASON) (Entered: 05/18/2023)
05/18/2023		Set/Reset Deadlines as to <u>57</u> MOTION for Temporary Restraining Order . (Internal deadline for referral to judge if response not filed earlier: 6/1/2023). (rcb) (Entered: 05/18/2023)
05/18/2023	<u>59</u>	SECOND AMENDED COMPLAINT against SCOT ACKERMAN, WAEL BARSOUM, MATTHEW R BENSON, GREGORY COFFMAN, CHRIS CREEGAN, AMY DERICK, DAVID DIAMOND, WATSON DUCATEL, FLORIDA BOARD OF MEDICINE, FLORIDA BOARD OF OSTEOPATHIC MEDICINE, MARIA GARCIA, PATRICK HUNTER, VALERIE JACKSON, NICOLE JUSTICE, WILLIAM D KIRSH, JOSEPH A LADAPO, MONICA M MORTENSEN, LUZ MARINA PAGES, ELEONOR PIMENTEL, NICHOLAS W ROMANELLO, TIFFANY SIZEMORE DI PIETRO, HECTOR VILA, MICHAEL WASYLIK, GREGORY WILLIAMS,

		ZACHARIAH P ZACHARIAH, ASHLEY MOODY, Ginger B Madden, Jack Campbell, John Durrett, Melissa Nelson, William Gladson, BRUCE BARTLETT, R.J. Larizza, BRIAN S KRAMER, BRIAN HAAS, KATHERINE FERNANDEZ RUNDLE, ED BRODSKY, Lopez S Susan, DAVE ARONBERG, Dennis Ward, Harold F Pryor, Phil Archer, Thomas Bakkedahl, Amira D Fox, filed by FIONA FOE, LISA LOE, SUSAN DOE, JANE DOE, PAUL POE, GAVIN GOE, LINDA LOE, CHRISTINA COE, BRENDA BOE, FREYA FOE, BENNETT BOE, GLORIA GOE, PATRICIA POE, CARLA COE. (CHRISS, SIMONE) (Entered: 05/18/2023)
05/19/2023	60	NOTICE of Filing Summons by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LINDA LOE, LISA LOE, PATRICIA POE, PAUL POE (Attachments: # 1 Exhibit Summons to Moody, # 2 Exhibit Summons to Madden, # 3 Exhibit Summons to Campbell, # 4 Exhibit Summons to Durrett, # 5 Exhibit Summons to Nelson, # 6 Exhibit Summons to Gladson, # 7 Exhibit Summons to Bartlett, # 8 Exhibit Summons to Larizza, # 9 Exhibit Summons to Kramer, # 10 Exhibit Summons to Worrell, # 11 Exhibit Summons to Haas, # 12 Exhibit Summons to Rundle, # 13 Exhibit Summons to Brodsky, # 14 Exhibit Summons to Lopez, # 15 Exhibit Summons to Basford, # 16 Exhibit Summons to Aronberg, # 17 Exhibit Summons to Ward, # 18 Exhibit Summons to Pryor, # 19 Exhibit Summons to Archer, # 20 Exhibit Summons to Bakkedahl, # 21 Exhibit Summons to Fox) (DUNN, CHELSEA) (Entered: 05/19/2023)
05/19/2023	61	Summons Issued as to ASHLEY MOODY (Attachments: # 1 SUMMONS ISSUED-BRIAN S. KRAMER, # 2 SUMMONS ISSUED-BRUCE BARTLETT, # 3 SUMMONS ISSUED-GINGER BOWEN MADDEN, # 4 SUMMONS ISSUED-JOHN DURRETT, # 5 SUMMONS ISSUED-MONIQUE H. WORRELL, # 6 SUMMONS ISSUED-RJ LARIZZA, # 7 SUMMONS ISSUED-WILLIAM GLADSON, # 8 SUMMONS ISSUED-JACK CAMPBELL, # 9 SUMMONS ISSUED-MELISSA NELSON) (rcb) (Entered: 05/19/2023)
05/19/2023	62	Summons Issued as to DAVE ARONBERG, LARRY BASFORD, Thomas Bakkedahl, Amira D Fox, BRIAN HAAS, BRIAN S KRAMER, Harold F Pryor, KATHERINE FERNANDEZ RUNDLE, Lopez S Susan, Dennis Ward. (Attachments: # 1 SUMMONS ISSUED-KATHERINE FERNANDEZ RUNDLE, # 2 SUMMONS ISSUED-THOMAS BAKKEDAH, # 3 SUMMONS ISSUED-BRIAN HAAS, # 4 SUMMONS ISSUED-BRIAN K KRAMER, # 5 SUMMONS ISSUED-SUSAN S LOPEZ, # 6 SUMMONS ISSUED-LARRY BASFORD, # 7 SUMMONS ISSUED-DAVE ARONBERG, # 8 SUMMONS ISSUED-DENNIS W WARD, # 9 SUMMONS ISSUED-HAROLD F PRYOR) (rcb) (Entered: 05/19/2023)
05/19/2023	63	Minute Entry for proceedings held before JUDGE ROBERT L HINKLE: Motion Hearing held on 5/19/2023. Court hears argument of counsel on plaintiffs' motions for 30 preliminary injunction and 57 temporary restraining order. Ruling by Court: The motions are taken under advisement. An order will follow. (Court Reporter Judy Gagnon, Contract Reporter) (ckm) (Entered: 05/19/2023)
05/19/2023	64	Summons Issued as to Phil Archer. (Attachments: # 1 SUMMONS ISSUED-ED BRODSKY) (rcb) (Entered: 05/19/2023)
05/20/2023	65	ORDER GRANTING 56 LEAVE TO FILE THE SECOND AMENDED COMPLAINT. The second amended complaint, ECF No. 56 -1, is deemed filed as of May 19, 2023. Signed by JUDGE ROBERT L HINKLE on 5/20/2023, nunc pro tunc 5/18/2023. (rcb) (Entered: 05/22/2023)
05/22/2023	66	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Proceedings held on 5/19/23, before Judge Robert Hinkle. Contract Court Reporter Judy A. Gagnon. Preliminary Injunction and Temporary Restraining Hearing. <i>Transcript may be viewed at the court public terminal or purchased through the Contract Court Reporter before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER.</i> Redaction Request due 5/30/2023 . Release of Transcript Restriction set for 8/28/2023 . (bkp) (Entered: 05/22/2023)
05/26/2023	67	SUMMONS Returned Executed by FIONA FOE, LISA LOE, PAUL POE, GAVIN GOE, LINDA LOE, GLORIA GOE, SUSAN DOE, JANE DOE, CHRISTINA COE, BRENDA BOE, FREYA FOE,

		BENNETT BOE, CARLA COE, PATRICIA POE. KATHERINE FERNANDEZ RUNDLE served on 5/19/2023, answer due 6/9/2023. (CHRISS, SIMONE) (Entered: 05/26/2023)
05/26/2023	68	SUMMONS Returned Executed by FIONA FOE, LISA LOE, PAUL POE, GAVIN GOE, LINDA LOE, GLORIA GOE, SUSAN DOE, JANE DOE, CHRISTINA COE, BRENDA BOE, FREYA FOE, BENNETT BOE, CARLA COE, PATRICIA POE. DAVE ARONBERG served on 5/22/2023, answer due 6/12/2023; BRUCE BARTLETT served on 5/22/2023, answer due 6/12/2023; Thomas Bakkedahl served on 5/22/2023, answer due 6/12/2023; Amira D Fox served on 5/22/2023, answer due 6/12/2023; BRIAN S KRAMER served on 5/22/2023, answer due 6/12/2023; R.J. Larizza served on 5/22/2023, answer due 6/12/2023; ASHLEY MOODY served on 5/22/2023, answer due 6/12/2023; Melissa Nelson served on 5/22/2023, answer due 6/12/2023; Harold F Pryor served on 5/22/2023, answer due 6/12/2023; Dennis Ward served on 5/22/2023, answer due 6/12/2023; SUSAN S LOPEZ served on 5/22/2023, answer due 6/12/2023. (Attachments: # 1 Affidavit Service on Aronberg, # 2 Affidavit Service on Bakkedahl, # 3 Affidavit Service on Bartlett, # 4 Affidavit Service on Fox, # 5 Affidavit Service on Kramer, # 6 Affidavit Service on Larizza, # 7 Affidavit Service on Lopez, # 8 Affidavit Service on Nelson, # 9 Affidavit Service on Pryor, # 10 Affidavit Service on Ward) (CHRISS, SIMONE) (Entered: 05/26/2023)
05/26/2023	69	SUMMONS Returned Executed by FIONA FOE, LISA LOE, PAUL POE, GAVIN GOE, LINDA LOE, GLORIA GOE, SUSAN DOE, JANE DOE, CHRISTINA COE, BRENDA BOE, FREYA FOE, BENNETT BOE, CARLA COE, PATRICIA POE. John Durrett served on 5/23/2023, answer due 6/13/2023; William Gladson served on 5/23/2023, answer due 6/13/2023. (Attachments: # 1 Affidavit Service on Gladson) (CHRISS, SIMONE) (Entered: 05/26/2023)
05/26/2023	70	SUMMONS Returned Executed by FIONA FOE, LISA LOE, PAUL POE, GAVIN GOE, LINDA LOE, GLORIA GOE, SUSAN DOE, JANE DOE, CHRISTINA COE, BRENDA BOE, FREYA FOE, BENNETT BOE, CARLA COE, PATRICIA POE. LARRY BASFORD served on 5/24/2023, answer due 6/14/2023. (CHRISS, SIMONE) (Entered: 05/26/2023)
05/30/2023	71	ORDER setting an additional hearing on the motions for a temporary restraining order and preliminary injunction. Signed by JUDGE ROBERT L HINKLE on 5/30/23. (RH) (Entered: 05/30/2023)
05/30/2023	72	NOTICE OF HEARING on 30 Telephonic hearing on the Motions for a temporary restraining order and preliminary injunction set for 6/1/2023 at 2:00 P>M> Call in number: 888-684-8852 Access code: 3243416# Security code: 1234# <i>Proceedings may not be recorded or otherwise broadcast for public dissemination.</i> <u>s/ Sherrye Stephens></u> Judicial Assistant. (sms). (Entered: 05/30/2023)
05/30/2023	73	ORDER CORRECTING DATE OF THE ADDITIONAL HEARING. Signed by JUDGE ROBERT L HINKLE on 5/30/23. (sms) (Entered: 05/30/2023)
05/30/2023	74	MOTION to Appear Pro Hac Vice by Shannon Minter.(Filing fee \$ 208 receipt number AFLNDC-7894090.) by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LINDA LOE, LISA LOE, PATRICIA POE, PAUL POE. (MINTER, SHANNON) (Entered: 05/30/2023)
05/30/2023		Set Deadlines-Re: 71 Plaintiff's Service of Copies on Defendants by noon on 5/31/2023 . Motions for a Temporary Restraining Order and Preliminary Injunction set for 6/1/2023 02:00 AM in U.S. Courthouse Tallahassee before JUDGE ROBERT L HINKLE. (rcb) (Entered: 05/31/2023)
05/31/2023		ACTION REQUIRED BY MAGISTRATE JUDGE: Chambers of MAGISTRATE JUDGE MARTIN A FITZPATRICK notified that action is needed Re: 74 MOTION to Appear Pro Hac Vice by Shannon Minter.(Filing fee \$ 208 receipt number AFLNDC-7894090.). Referred to MARTIN A FITZPATRICK. (rcb) (Entered: 05/31/2023)

05/31/2023	75	SUMMONS Returned Executed by FIONA FOE, LISA LOE, PAUL POE, GAVIN GOE, LINDA LOE, GLORIA GOE, SUSAN DOE, JANE DOE, CHRISTINA COE, BRENDA BOE, FREYA FOE, BENNETT BOE, CARLA COE, PATRICIA POE. MONIQUE H WORRELL served on 5/22/2023, answer due 6/12/2023. (CHRISS, SIMONE) (Entered: 05/31/2023)
05/31/2023	76	SUMMONS Returned Executed by FIONA FOE, LISA LOE, PAUL POE, GAVIN GOE, LINDA LOE, GLORIA GOE, SUSAN DOE, JANE DOE, CHRISTINA COE, BRENDA BOE, FREYA FOE, BENNETT BOE, CARLA COE, PATRICIA POE. BRIAN HAAS served on 5/24/2023, answer due 6/14/2023. (CHRISS, SIMONE) (Entered: 05/31/2023)
05/31/2023	77	SUMMONS Returned Executed by FIONA FOE, LISA LOE, PAUL POE, GAVIN GOE, LINDA LOE, GLORIA GOE, SUSAN DOE, JANE DOE, CHRISTINA COE, BRENDA BOE, FREYA FOE, BENNETT BOE, CARLA COE, PATRICIA POE. Ginger B Madden served on 5/25/2023, answer due 6/15/2023. (CHRISS, SIMONE) (Entered: 05/31/2023)
05/31/2023	78	SUMMONS Returned Executed by FIONA FOE, LISA LOE, PAUL POE, GAVIN GOE, LINDA LOE, GLORIA GOE, SUSAN DOE, JANE DOE, CHRISTINA COE, BRENDA BOE, FREYA FOE, BENNETT BOE, CARLA COE, PATRICIA POE. Jack Campbell served on 5/26/2023, answer due 6/16/2023. (CHRISS, SIMONE) (Entered: 05/31/2023)
05/31/2023	79	NOTICE of Appearance by WILLIAM HENRY STAFFORD, III on behalf of ASHLEY MOODY (STAFFORD, WILLIAM) (Entered: 05/31/2023)
05/31/2023	80	MOTION to Dismiss by ASHLEY MOODY. (Internal deadline for referral to judge if response not filed earlier: 6/14/2023). (STAFFORD, WILLIAM) (Entered: 05/31/2023)
06/01/2023		ACTION REQUIRED BY DISTRICT JUDGE: Chambers of JUDGE ROBERT L HINKLE notified that action is needed Re: 79 Notice of Appearance **AN ISO IS NEEDED** (rcb) (Entered: 06/01/2023)
06/01/2023	81	Minute Entry for proceedings held before JUDGE ROBERT L HINKLE: Telephonic Motion Hearing held on 6/1/2023. Court hears argument re: Plaintiffs' 57 Motion for Temporary Restraining Order and 30 Motion for Preliminary Injunction. Ruling by Court: An order is forthcoming (Court Reporter Megan Hague (USDC-Tallahassee)). (vkm) (Entered: 06/01/2023)
06/02/2023	82	ORDER. Accordingly, it is ORDERED that the motion for leave to appear pro hac vice, ECF No. 74 , is GRANTED. Signed by MAGISTRATE JUDGE MARTIN A FITZPATRICK on 06/02/2023. (rcb) (Entered: 06/02/2023)
06/02/2023	83	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Telephonic Proceedings held on 6/1/2023, before Judge Robert L. Hinkle. Court Reporter/Transcriber Megan A. Hague, Telephone number 850-443-9797. <i>Transcript may be viewed at the court public terminal or purchased through the Court Reporter/Transcriber before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER.</i> Redaction Request due 6/9/2023 . Release of Transcript Restriction set for 9/7/2023 . (mah) (Entered: 06/02/2023)
06/02/2023	84	SUMMONS Returned Executed by FIONA FOE, LISA LOE, PAUL POE, GAVIN GOE, LINDA LOE, GLORIA GOE, SUSAN DOE, JANE DOE, CHRISTINA COE, BRENDA BOE, FREYA FOE, BENNETT BOE, CARLA COE, PATRICIA POE. Ed Brodsky served on 5/30/2023, answer due 6/20/2023. (CHRISS, SIMONE) (Entered: 06/02/2023)
06/02/2023	85	SUMMONS Returned Executed by FIONA FOE, LISA LOE, PAUL POE, GAVIN GOE, LINDA LOE, GLORIA GOE, SUSAN DOE, JANE DOE, CHRISTINA COE, BRENDA BOE, FREYA FOE, BENNETT BOE, CARLA COE, PATRICIA POE. Phil Archer served on 5/31/2023, answer due 6/21/2023. (CHRISS, SIMONE) (Entered: 06/02/2023)
06/02/2023	86	SEALED # 1 COVER LETTER) (rcb) (Entered: 06/02/2023)

06/02/2023	87	DOCKET ANNOTATION BY COURT: Re 86 Sealed Document **FORWARDED TO CHAMBERS** (rcb) (Entered: 06/02/2023)
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06/05/2023	88	NOTICE of <i>NON-OBJECTION</i> by DAVE ARONBERG, Phil Archer, BRUCE BARTLETT, LARRY BASFORD, Thomas Bakkedahl, Ed Brodsky, Jack Campbell, John Durrett, Amira D Fox, William Gladson, BRIAN HAAS, BRIAN S KRAMER, SUSAN S LOPEZ, R.J. Larizza, ASHLEY MOODY, Ginger B Madden, Melissa Nelson, Harold F Pryor, KATHERINE FERNANDEZ RUNDLE, Lopez S Susan, MONIQUE H WORRELL, Dennis Ward (STAFFORD, WILLIAM) (Entered: 06/05/2023)
06/05/2023	89	NOTICE of Appearance by ARTHUR IVAN JACOBS on behalf of DAVE ARONBERG, Phil Archer, BRUCE BARTLETT, LARRY BASFORD, Thomas Bakkedahl, Ed Brodsky, Jack Campbell, John Durrett, Amira D Fox, William Gladson, BRIAN HAAS, BRIAN S KRAMER, SUSAN S LOPEZ, R.J. Larizza, Ginger B Madden, Harold F Pryor, KATHERINE FERNANDEZ RUNDLE, Lopez S Susan, MONIQUE H WORRELL, Dennis Ward (JACOBS, ARTHUR) (Entered: 06/05/2023)
06/06/2023		ACTION REQUIRED BY DISTRICT JUDGE: Chambers of JUDGE ROBERT L HINKLE notified that action is needed Re: 89 Notice of Appearance, (rcb)**AN ISO IS NEEDED** (Entered: 06/06/2023)
06/06/2023	90	ORDER granting in part and denying in part 30 Motion for Preliminary Injunction; finding as moot 57 Motion for TRO. Signed by JUDGE ROBERT L HINKLE on 6/6/23. (sms) (Entered: 06/06/2023)
06/06/2023	91	INITIAL SCHEDULING ORDER. Rule 26 Meeting Report due by 7/20/2023 . Discovery due by 1/5/2024 . Attorney Conference due by 7/6/2023 . Jury Trial set for 4/15/2024 08:15 AM in U.S. Courthouse Tallahassee before JUDGE ROBERT L HINKLE. Signed by JUDGE ROBERT L HINKLE on 06/06/2023. (rcb) (Entered: 06/06/2023)
06/06/2023	92	Cash Injunction Bond Received Re: 90 : \$ 100.00, receipt number 400000526. Fee status updated to <i>paid</i> . (rcb) (Entered: 06/07/2023)
06/08/2023	93	MOTION to Appear Pro Hac Vice by Thomas E. Redburn, Jr.(Filing fee \$ 208 receipt number AFLNDC-7909650.) by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LINDA LOE, LISA LOE, PATRICIA POE, PAUL POE. (Attachments: # 1 Exhibit A - Certificate of Good Standing) (REDBURN, THOMAS) (Entered: 06/08/2023)
06/08/2023	94	MOTION to Appear Pro Hac Vice by Maya Ginsburg.(Filing fee \$ 208 receipt number AFLNDC-7910051.) by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LINDA LOE, LISA LOE, PATRICIA POE, PAUL POE. (Attachments: # 1 Exhibit A - Certificate of Good Standing) (GINSBURG, MAYA) (Entered: 06/08/2023)
06/09/2023		ACTION REQUIRED BY MAGISTRATE JUDGE: Chambers of MAGISTRATE JUDGE MARTIN A FITZPATRICK notified that action is needed Re: 93 MOTION to Appear Pro Hac Vice by Thomas E. Redburn, Jr.(Filing fee \$ 208 receipt number AFLNDC-7909650.), 94 MOTION to Appear Pro Hac Vice by Maya Ginsburg.(Filing fee \$ 208 receipt number AFLNDC-7910051.). Referred to MARTIN A FITZPATRICK. (rcb) (Entered: 06/09/2023)
06/13/2023	95	ORDER. The motion for leave to appear pro hac vice, ECF No. 93 , is GRANTED. The motion for leave to appear pro hac vice, ECF No. 94 , is GRANTED. Signed by MAGISTRATE JUDGE MARTIN A FITZPATRICK on 06/13/2023. (rcb) (Entered: 06/13/2023)
06/14/2023	96	NOTICE OF APPEARANCE AS ADDITIONAL COUNSEL FOR DEFENDANTS (STAFFORD, WILLIAM) Modified to edit title on 6/15/2023 (rcb). (Entered: 06/14/2023)
06/14/2023	97	NOTICE of Voluntary Dismissal by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LINDA LOE, LISA LOE, PATRICIA POE, PAUL POE (CHRISS, SIMONE) (Entered: 06/14/2023)
06/15/2023		ACTION REQUIRED BY MAGISTRATE JUDGE: Chambers of MAGISTRATE JUDGE MARTIN A FITZPATRICK notified that action is needed Re: 96 NOTICE of Appearance, 97 NOTICE of

06/15/2023	<u>98</u>	NOTICE of Appearance by WILLIAM HENRY STAFFORD, III on behalf of William Gladson (STAFFORD, WILLIAM) (Entered: 06/15/2023)
06/15/2023	<u>99</u>	ORDER DISMISSING THE CLAIMS AGAINST THE ATTORNEY GENERAL. The notice of voluntary dismissal, ECF No. <u>97</u> , is deemed a motion to amend the second amended complaint to delete the claims against the Attorney General. The motion is granted. All claims against the Attorney General are dismissed without prejudice. The Attorney General's motion to dismiss, ECF No. <u>80</u> , is denied as moot. I do not direct the entry of judgment under Federal Rule of Civil Procedure 54(b). The claims against other defendants remain pending. Signed by JUDGE ROBERT L HINKLE on 06/15/2023. (rcb) (Entered: 06/16/2023)
06/19/2023	<u>100</u>	STIPULATION of Dismissal by DAVE ARONBERG, Phil Archer, BRUCE BARTLETT, LARRY BASFORD, Thomas Bakkedahl, Ed Brodsky, Jack Campbell, John Durrett, Amira D Fox, William Gladson, BRIAN HAAS, BRIAN S KRAMER, R.J. Larizza, Ginger B Madden, Harold F Pryor, KATHERINE FERNANDEZ RUNDLE, Lopez S Susan, MONIQUE H WORRELL, Dennis Ward. (JACOBS, ARTHUR) (Entered: 06/19/2023)
06/19/2023	<u>101</u>	STIPULATION of Dismissal by Melissa Nelson. (JACOBS, ARTHUR) (Entered: 06/19/2023)
06/22/2023	<u>102</u>	NOTICE of Appearance by JOSEPH EDWARD HART on behalf of WILLIAM GLADSON (HART, JOSEPH) (Entered: 06/22/2023)
06/22/2023	<u>103</u>	STIPULATION AND ORDER OF DISMISSAL OF STATE ATTORNEYS DEFENDANTS UPON CONDITIONS. By agreement of the Stipulating parties as set forth below, and pursuant to Federal Rule of Civil Procedure 21 and 4l(a)(l), the eighteen above-listed Defendant State Attorneys (the "Dismissed State Attorneys") are hereby dismissed without prejudice. Defendant State Attorney WILLIAM M GLADSON in his official capacity as State Attorney for the Fifth Judicial Circuit of Florida ("State Attorney Gladson") is not a party to this stipulation and will remain a Defendant in the lawsuit. This Order does not dismiss any claims against any Defendants except as expressly provided herein. Signed by JUDGE ROBERT L HINKLE on 06/22/2023. (rcb) (Entered: 06/22/2023)
06/22/2023	<u>104</u>	NOTICE of Appearance by MAYA GINSBURG on behalf of BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LINDA LOE, LISA LOE, PATRICIA POE, PAUL POE (GINSBURG, MAYA) (Entered: 06/22/2023)
06/22/2023	<u>105</u>	NOTICE of Appearance by THOMAS EDWARD REDBURN, JR on behalf of BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LINDA LOE, LISA LOE, PATRICIA POE, PAUL POE (REDBURN, THOMAS) (Entered: 06/22/2023)
06/23/2023	<u>106</u>	CONSOLIDATED ANSWER to <u>59</u> Amended Complaint,,, BY ALL DEFENDANTS TO PLAINTIFFS' SECOND AMENDED COMPLAINT by SCOT ACKERMAN, Wael Barsoum, Matthew R Benson, Gregory Coffman, Chris Creegan, Amy Derick, David Diamond, Watson Ducatel, Florida Board of Medicine, Florida Board of Osteopathic Medicine, Maria Garcia, Patrick Hunter, Valerie Jackson, Nicole Justice, William D Kirsh, Joseph A Ladapo, Monica M Mortensen, Luz Marina Pages, Eleonor Pimentel, Nicholas W Romanello, Tiffany Sizemore Di Pietro, Hector Vila, Zachariah P Zachariah. (JAZIL, MOHAMMAD) (Entered: 06/23/2023)
06/23/2023	<u>107</u>	CORRECTED, CONSOLIDATED ANSWER to <u>59</u> Amended Complaint,,, BY ALL DEFENDANTS TO PLAINTIFFS' SECOND AMENDED COMPLAINT by SCOT ACKERMAN, Wael Barsoum, Matthew R Benson, Gregory Coffman, Chris Creegan, Amy Derick, David Diamond, Watson Ducatel, Florida Board of Medicine, Florida Board of Osteopathic Medicine, Maria Garcia, William Gladson, Patrick Hunter, Valerie Jackson, Nicole Justice, William D Kirsh, Brian S Kramer, Joseph A Ladapo, Monica M Mortensen, Luz Marina Pages, Eleonor Pimentel, Nicholas W Romanello, Tiffany Sizemore Di Pietro, Hector Vila, Michael

		WASYLIK, GREGORY WILLIAMS, ZACHARIAH P ZACHARIAH. (JAZIL, MOHAMMAD) (Entered: 06/23/2023)
06/26/2023	108	USCA11 Case: 23-12159 Document: 34-1 Date Filed: 09/13/2023 Page: 53 of 249 NOTICE OF APPEAL as to 90 Order on Motion for Preliminary Injunction, Order on Motion for TRO by SCOT ACKERMAN, WAEI BARSOUM, MATTHEW R BENSON, GREGORY COFFMAN, CHRIS CREEGAN, AMY DERICK, DAVID DIAMOND, WATSON DUCATEL, FLORIDA BOARD OF MEDICINE, FLORIDA BOARD OF OSTEOPATHIC MEDICINE, MARIA GARCIA, WILLIAM GLADSON, PATRICK HUNTER, VALERIE JACKSON, NICOLE JUSTICE, WILLIAM D KIRSH, JOSEPH A LADAPO, MONICA M MORTENSEN, LUZ MARINA PAGES, ELEONOR PIMENTEL, NICHOLAS W ROMANELLO, TIFFANY SIZEMORE DI PIETRO, HECTOR VILA, MICHAEL WASYLIK, GREGORY WILLIAMS, ZACHARIAH P ZACHARIAH. (Filing fee \$505 Receipt Number AFLNDC-7940814.) (Attachments: # 1 Exhibit Doc. 90, Preliminary Injunction Order) (JAZIL, MOHAMMAD) (Entered: 06/26/2023)
06/27/2023	109	Transmission of Notice of Appeal and Docket Sheet to US Court of Appeals re 108 Notice of Appeal. (rcb) (Entered: 06/27/2023)
06/27/2023		Set Deadlines re 108 Notice of Appeal. Clerk to check status of Appeal on 9/25/2023 . Certificate of Readiness (FRAP 11) due by 7/11/2023 . (rcb) (Entered: 06/27/2023)
06/30/2023	110	TRANSCRIPT REQUEST by WAEI BARSOUM, MATTHEW R BENSON, GREGORY COFFMAN, CHRIS CREEGAN, AMY DERICK, DAVID DIAMOND, FLORIDA BOARD OF MEDICINE, FLORIDA BOARD OF OSTEOPATHIC MEDICINE, MARIA GARCIA, WILLIAM GLADSON, PATRICK HUNTER, VALERIE JACKSON, NICOLE JUSTICE, WILLIAM D KIRSH, JOSEPH A LADAPO, MONICA M MORTENSEN, LUZ MARINA PAGES, ELEONOR PIMENTEL, TIFFANY SIZEMORE DI PIETRO, HECTOR VILA, GREGORY WILLIAMS, ZACHARIAH P ZACHARIAH for proceedings held on May 19, 2023 before Judge Judge Robert L. Hinkle, Court Reporter:Judy Gagnon (BEATO, MICHAEL) (Entered: 06/30/2023)
07/05/2023	111	USCA Acknowledgment # 23-12159 for 108 NOTICE OF APPEAL ** (rcb) (Entered: 07/05/2023)
07/11/2023	112	Pursuant to F.R.A.P. 11(c), #23-12159 the Clerk of the District Court for the Northern District of Florida certifies that the record is complete for purposes of this appeal re: 108 Notice of Appeal. The entire record on appeal is available electronically. (rcb) (Entered: 07/11/2023)
07/20/2023	113	REPORT of Rule 26(f) Planning Meeting. (REDBURN, THOMAS) (Entered: 07/20/2023)
07/21/2023	114	PLAINTIFFS' MOTION FOR LEAVE TO FILE A THIRD AMENDED COMPLAINT AND JOIN NEW PLAINTIFFS. (Attachments: # 1 Exhibit A - Third Amended Complaint) (REDBURN, THOMAS) Modified to edit title on 7/24/2023 (rcb). Modified to terminate ECF 114 on 7/28/2023 (rcb). (Entered: 07/21/2023)
07/24/2023		Set/Reset Deadlines as to 114 MOTION to Amend/Correct 1 Complaint, . (Internal deadline for referral to judge if response not filed earlier: 8/7/2023). (rcb) (Entered: 07/24/2023)
07/24/2023	115	MOTION for Preliminary Injunction by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LINDA LOE, LISA LOE, PATRICIA POE, PAUL POE. (Attachments: # 1 Exhibit Declaration of Kai Pope, # 2 Exhibit Declaration of Lucien Hamel, # 3 Exhibit Declaration of Olivia Noel, # 4 Exhibit Declaration of Rebecca Cruz Evia, # 5 Exhibit Expert Declaration of Dan H. Karasic, M.D., # 6 Exhibit Expert Declaration of Daniel Shumer, M.D., # 7 Exhibit Expert Declaration of Dr. Loren Schechter, # 8 Exhibit Expert Declaration of Vernon Langford, DNP, # 9 Exhibit Supplemental Expert Declaration of Kenneth Goodman PhD, # 10 Text of Proposed Order Proposed Order) (CHRISS, SIMONE) (Entered: 07/24/2023)
07/24/2023	116	MEMORANDUM in Support re 115 MOTION for Preliminary Injunction filed by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LINDA LOE, LISA LOE, PATRICIA POE, PAUL POE. (CHRISS, SIMONE) (Entered: 07/24/2023)
07/27/2023	117	SCHEDULING ORDER. The clerk must set a scheduling conference by telephone for the first available date. The plaintiff's motion, ECF No. 114 , for leave to file the third amended complaint is granted. The third amended complaint, ECF No. 114 -1, is deemed filed as of July 27, 2023. The

		bench trial is set for Monday, 11/13/2023 at 09:00 AM in U.S. Courthouse Tallahassee before JUDGE ROBERT L HINKLE. A party with a conflict must file a notice by 8/10/2023. The fact-discovery deadline is 8/9/2023. Document discovery date filed: 9/8/23/2023 by 10/23/2023 of 249 exhibits a party expects to present must be pre-filed on the CM/ECF docket signed by JUDGE ROBERT L HINKLE on 7/27/2023. (Entered: 07/28/2023)
07/27/2023		Set Deadlines- Re: 117 Fact Discovery due by 8/9/2023. All Exhibit due by 10/23/2023. Expert Discovery - by 9/18/2023. Bench Trial set for 11/13/2023 09:00 AM in U.S. Courthouse Tallahassee before JUDGE ROBERT L HINKLE. (rcb) (Entered: 07/28/2023)
07/27/2023	118	THIRD AMENDED COMPLAINT against All Defendants, filed by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LINDA LOE, LISA LOE, PATRICIA POE, LUCIEN HAMEL, PAUL POE, OLIVIA NOEL, REBECCA CRUZ EVIA AND KAI POPE. (rcb) (Entered: 07/31/2023)
07/31/2023	119	NOTICE OF TELEPHONIC HEARING: Telephonic Scheduling Conference set for 8/10/2023 01:00 PM before JUDGE ROBERT L HINKLE. Call in number: 888-684-8852 Access code: 3243416# Security code: 1234# <i>Proceedings may not be recorded or otherwise broadcast for public dissemination.</i> <u>s/ Cindy Markley</u> Courtroom Deputy Clerk (ckm) (Entered: 07/31/2023)
07/31/2023	120	MOTION to Certify Class by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LINDA LOE, LISA LOE, PATRICIA POE, PAUL POE, LUCIEN HAMEL, OLIVIA NOEL, REBECCA CRUZ EVIA, KAI POPE. (Internal deadline for referral to judge if response not filed earlier: 8/14/2023). (REDBURN, THOMAS) (Entered: 07/31/2023)
07/31/2023	121	MEMORANDUM in Support re 120 MOTION to Certify Class filed by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, REBECCA CRUZ EVIA, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LUCIEN HAMEL, LINDA LOE, LISA LOE, OLIVIA NOEL, PATRICIA POE, PAUL POE, KAI POPE. (Attachments: # 1 Declaration of Thomas E. Redburn, Jr., # 2 Exhibit A - LS Firm Resume, # 3 Exhibit B - Simone Chriss Bio & CV, # 4 Exhibit C - Jennifer L. Levi - GLAD, # 5 Exhibit D - Impact Litigation and Advocacy - HRC Foundation, # 6 Exhibit E - Williams Institute Trans-Pop-Update-Jun-2022) (REDBURN, THOMAS) (Entered: 07/31/2023)
08/01/2023	122	NOTICE of Appearance by JOSHUA E PRATT on behalf of SCOT ACKERMAN, WAE BARSOUM, MATTHEW R BENSON, GREGORY COFFMAN, CHRIS CREEGAN, AMY DERICK, DAVID DIAMOND, WATSON DUCATEL, FLORIDA BOARD OF MEDICINE, FLORIDA BOARD OF OSTEOPATHIC MEDICINE, MARIA GARCIA, PATRICK HUNTER, VALERIE JACKSON, NICOLE JUSTICE, WILLIAM D KIRSH, JOSEPH A LADAPO, MONICA M MORTENSEN, ELEONOR PIMENTEL, NICHOLAS W ROMANELLO, TIFFANY SIZEMORE DI PIETRO, HECTOR VILA, MICHAEL WASYLIK, GREGORY WILLIAMS, ZACHARIAH P ZACHARIAH (PRATT, JOSHUA) (Entered: 08/01/2023)
08/03/2023	123	Joint MOTION for Protective Order <i>and HIPAA Qualified Protective Order & Order to Disclose Protective Health Information</i> by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, REBECCA CRUZ EVIA, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LUCIEN HAMEL, LINDA LOE, LISA LOE, OLIVIA NOEL, PATRICIA POE, PAUL POE, KAI POPE. (Attachments: # 1 Exhibit 1 - Stipulated Protective Order with Attachment A, # 2 Exhibit 2 - Proposed HIPAA Protective Order) (REDBURN, THOMAS) Modified on 8/4/2023 to terminate motion (ckm). (Entered: 08/03/2023)
08/03/2023	124	STIPULATED PROTECTIVE ORDER Re: 123 . Signed by JUDGE ROBERT L HINKLE on 8/3/2023. (rcb) Modified to add ECF 123 link on 8/10/2023 (rcb). (Entered: 08/03/2023)

08/03/2023	<u>125</u>	HIPAA QUALIFIED PROTECTIVE ORDER AND ORDER TO DISCLOSE PROTECTED HEALTH INFORMATION Re: <u>123</u> . Signed by JUDGE ROBERT L HINKLE on 8/3/2023. (rcb) Modified to add ECF <u>123</u> link on 8/10/2023 (rcb). (Entered: 08/03/2023)
08/07/2023	<u>126</u>	THE STATE'S RESPONSE IN OPPOSITION TO THE PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION AND MEMORADUM OF LAW. (JAZIL, MOHAMMAD) Modified to edit title on 8/8/2023 (rcb). (Entered: 08/07/2023)
08/07/2023	<u>127</u>	THE STATE'S AMENDED RESPONSE IN OPPOSITION TO THE PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION AND MEMORADUM OF LAW. (Attachments: # <u>1</u> Exhibit Ex A - Form - "Feminizing Medications for Patients with Gender Dysphoria", # <u>2</u> Exhibit Ex B - Form - "Masculinizing Medications for Patients with Gender Dysphoria", # <u>3</u> Exhibit Ex C - Form - "Surgical Treatment for Adults with Gender Dysphoria") (JAZIL, MOHAMMAD) Modified to edit title on 8/8/2023 (rcb). (Entered: 08/07/2023)
08/09/2023	<u>128</u>	MOTION for Leave to File re <u>127</u> Response in Opposition to Motion, <u>115</u> MOTION for Preliminary Injunction by REBECCA CRUZ EVIA, LUCIEN HAMEL, OLIVIA NOEL, KAI POPE. (CHRISS, SIMONE) (Entered: 08/09/2023)
08/10/2023		Set/Reset Deadlines as to <u>128</u> MOTION for Leave to File re <u>127</u> Response in Opposition to Motion, <u>115</u> MOTION for Preliminary Injunction . (Internal deadline for referral to judge if response not filed earlier: 8/24/2023). (rcb) (Entered: 08/10/2023)
08/10/2023	<u>129</u>	ORDER ALLOWING A REPLY MEMORANDUM ON THE <u>128</u> PRELIMINARY-INJUNCTION MOTION. The plaintiffs' motion, ECF No. <u>128</u> , for leave to file a reply memorandum in support of the preliminary-injunction motion is granted. The plaintiffs may file a reply memorandum by 8/14/2023 . Signed by JUDGE ROBERT L HINKLE on 8/10/2023. (rcb) (Entered: 08/10/2023)
08/10/2023	<u>130</u>	Minute Entry for proceedings held before JUDGE ROBERT L HINKLE: Telephonic Scheduling Conference held on 8/10/2023. Court recaps current schedule and hears from counsel regarding discovery issues. Ruling by Court: Defense to provide written reports by August 24 and transcripts by September 10. Courtroom deputy will coordinate with counsel a date for oral argument on the motion for class certification. (Court Reporter Megan Hague, Official Court Reporter) (ckm) (Entered: 08/10/2023)
08/10/2023	<u>131</u>	CONSOLIDATED ANSWER BY ALL DEFENDANTS TO PLAINTIFFS' THIRD AMENDED COMPLAINT. (JAZIL, MOHAMMAD) Modified to edit title on 8/11/2023 (rcb). (Entered: 08/10/2023)
08/11/2023	132	Pursuant to F.R.A.P. 11(c), #23-12159-J the Clerk of the District Court for the Northern District of Florida certifies that the record is complete for purposes of this appeal re: <u>108</u> Notice of Appeal. The entire record on appeal is available electronically. (rcb) (Entered: 08/11/2023)
08/11/2023	<u>133</u>	REPLY to Response to Motion re <u>128</u> MOTION for Leave to File re <u>127</u> Response in Opposition to Motion, <u>115</u> MOTION for Preliminary Injunction filed by REBECCA CRUZ EVIA, LUCIEN HAMEL, OLIVIA NOEL, KAI POPE. (Attachments: # <u>1</u> Exhibit A - Breast and Cervical Cancer Detection Program, # <u>2</u> Exhibit B - Authorization for Electroconvulsive Treatment, # <u>3</u> Exhibit C - Medical Marijuana Informed Consent, # <u>4</u> Exhibit D - Cataract Procedures Informed Consent) (CHRISS, SIMONE) (Entered: 08/11/2023)
08/11/2023	<u>134</u>	ORDER SETTING DEADLINES FOR PRODUCING RECORDS OF STATE PROCEEDINGS. By 8/11/2023 , the defendants must produce links to all the legislative and administrative proceedings. By 8/24/2023 , the defendants must produce the legislative and administrative materials other than transcripts of proceedings. By 9/10/2023 , the defendants must produce transcripts of the legislative and administrative proceedings. Signed by JUDGE ROBERT L HINKLE on 8/11/2023. (rcb) (Entered: 08/14/2023)
08/14/2023	<u>135</u>	THE STATE'S OPPOSITION TO THE PLAINTIFFS' MOTION FOR CLASS CERTIFICATION AND MEMORANDUM OF LAW. (JAZIL, MOHAMMAD) Modified to edit title on 8/15/2023 (rcb). (Entered: 08/14/2023)
08/16/2023	136	NOTICE OF HEARING on <u>120</u> Motion to Certify Class: Oral Argument set for 8/29/2023 03:00 PM before JUDGE ROBERT L HINKLE, Joseph Woodrow Hatchett United States Courthouse and

		Federal Building, Courtroom 5 East, 111 North Adams St., Tallahassee, Florida 32301. USCA11 Case: 18-12159 Document: 34-1 Date Filed: 08/13/2023 Page: 56 of 149 NOTE: If you or any party, witness or attorney in this matter has a disability that requires special accommodation, such as a hearing impairment that requires a sign language interpreter or a wheelchair restriction that requires ramp access, please contact Cindy Markley at 850-521-3518 in the Clerk's Office at least one week prior to the hearing (or as soon as possible) so arrangements can be made. <i>s/ Cindy Markley</i> Courtroom Deputy Clerk (ckm) (Entered: 08/16/2023)
08/18/2023	137	MOTION for Leave to File re 120 MOTION to Certify Class by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, REBECCA CRUZ EVIA, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LUCIEN HAMEL, LINDA LOE, LISA LOE, OLIVIA NOEL, PATRICIA POE, PAUL POE, KAI POPE. (REDBURN, THOMAS) (Entered: 08/18/2023)
08/21/2023	138	ORDER ALLOWING A REPLY MEMORANDUM IN SUPPORT OF THE MOTION FOR CLASS CERTIFICATION 137 . Signed by JUDGE ROBERT L HINKLE on 8/21/23. (sms) (Entered: 08/21/2023)
08/21/2023	139	NOTICE OF HEARING on 115 Motion for Preliminary Injunction: Motion Hearing set for 8/29/2023 03:00 PM before JUDGE ROBERT L HINKLE, Joseph Woodrow Hatchett United States Courthouse and Federal Building, Courtroom 5 East, 111 North Adams St., Tallahassee, Florida 32301. <i>PLEASE NOTE the parties will have 30 minutes total per side to argue both the 115 and 120 Motions.</i> NOTE: If you or any party, witness or attorney in this matter has a disability that requires special accommodation, such as a hearing impairment that requires a sign language interpreter or a wheelchair restriction that requires ramp access, please contact Cindy Markley at 850-521-3518 in the Clerk's Office at least one week prior to the hearing (or as soon as possible) so arrangements can be made. <i>s/ Cindy Markley</i> Courtroom Deputy Clerk (ckm) (Entered: 08/21/2023)
08/21/2023	140	REPLY to Response to Motion re 120 MOTION to Certify Class , 137 MOTION for Leave to File re 120 MOTION to Certify Class filed by BENNETT BOE, BRENDA BOE, CARLA COE, CHRISTINA COE, JANE DOE, SUSAN DOE, REBECCA CRUZ EVIA, FIONA FOE, FREYA FOE, GAVIN GOE, GLORIA GOE, LUCIEN HAMEL, LINDA LOE, LISA LOE, OLIVIA NOEL, PATRICIA POE, PAUL POE, KAI POPE. (REDBURN, THOMAS) (Entered: 08/21/2023)
08/21/2023		Set Deadline-Re: 138 - Reply due by 8/24/2023. (rcb) (Entered: 08/22/2023)
08/22/2023	141	<i>NOTICE OF SUPPLEMENTAL AUTHORITY</i> by SCOT ACKERMAN, WAEI BARSOUM, MATTHEW R BENSON, GREGORY COFFMAN, CHRIS CREEGAN, AMY DERICK, DAVID DIAMOND, WATSON DUCATEL, ENDOCRINE SOCIETY, FLORIDA BOARD OF MEDICINE, FLORIDA BOARD OF OSTEOPATHIC MEDICINE, MARIA GARCIA, PATRICK HUNTER, VALERIE JACKSON, NICOLE JUSTICE, WILLIAM D KIRSH, JOSEPH A LADAPO, MONICA M MORTENSEN, LUZ MARINA PAGES, ELEONOR PIMENTEL, NICHOLAS W ROMANELLO, TIFFANY SIZEMORE DI PIETRO, HECTOR VILA, MICHAEL WASYLIK, GREGORY WILLIAMS, ZACHARIAH P ZACHARIAH (Attachments: # 1 Exhibit Opinion, Eknes-Tucker v Governor of Alabama, 22-11707 (11th Cir. 2023)) (BEATO, MICHAEL) (Entered: 08/22/2023)
08/23/2023	142	<i>NOTICE OF SUPPLEMENTAL AUTHORITY</i> by REBECCA CRUZ EVIA, LUCIEN HAMEL, OLIVIA NOEL, KAI POPE (Attachments: # 1 Exhibit A - Notice of Emergency Rule No. 64B8ER23-11, # 2 Exhibit B - Notice of Emergency Rule 64B15ER23-12, # 3 Exhibit C - Form

08/27/2023	143	ORDER on scheduling of hearing: Current forecasts include a substantial probability of a hurricane coming ashore near Tallahassee on Wednesday morning. Prudence calls for conducting the Tuesday afternoon hearing by audio or video conference or rescheduling it for Friday or later. The parties should confer and advise the courtroom deputy clerk of their positions by telephone Monday morning. Issued by JUDGE ROBERT L HINKLE on 8/27/23. (RH) (Entered: 08/27/2023)
08/29/2023	144	NOTICE OF RESCHEDULED HEARING on 115 Motion for Preliminary Injunction and 120 Motion to Certify Class: The Motion Hearing that was scheduled for August 29, 2023 at 3:00 p.m. has been rescheduled for 9/1/2023 at 3:00 p.m. before JUDGE ROBERT L HINKLE and will be conducted by video. The video link will be sent by email to counsel. As noted previously, each side will have 30 minutes to argue the motions. Members of the general public may join by telephone but must keep their phones muted: Call in number: 888-684-8852 Access code: 3243416# Security code: 1234# <i>Proceedings may not be recorded or otherwise broadcast for public dissemination.</i> <i>s/ Cindy Markley</i> Courtroom Deputy Clerk (ckm) (Entered: 08/29/2023)
09/01/2023	145	Minute Entry for proceedings held before JUDGE ROBERT L HINKLE: Motion Hearing held by video on 9/1/2023. Court hears argument of counsel on plaintiffs' 115 motion for preliminary injunction and 120 motion to certify class. Ruling by Court: Plaintiffs will file medical information for specific plaintiffs for whom injunction is sought. Defense will have an opportunity to respond. An order will follow. (Court Reporter Donna Boland, Official Court Reporter) (ckm) (Entered: 09/01/2023)
09/05/2023	146	JOINT MOTION FOR ENTRY OF (1) PROTECTIVE ORDER AND (2) HIPAA QUALIFIED PROTECTIVE ORDER AND ORDER TO DISCLOSE PROTECTED HEALTH INFORMATION. (Attachments: # 1 Exhibit 1 - Stipulated Protective Order with Attachment A, # 2 Exhibit 2 - Proposed HIPAA Protective Order) (REDBURN, THOMAS) Modified to edit title on 9/6/2023 (rcb). (Entered: 09/05/2023)
09/06/2023	147	COVER LETTER (Attachments: # 1 SEALED MEDICAL RECORDS, # 2 SEALED MEDICAL RECORDS, # 3 SEALED MEDICAL RECORDS, # 4 SEALED MEDICAL RECORDS, # 5 SEALED MEDICAL RECORDS, # 6 SEALED MEDICAL RECORDS, # 7 SEALED MEDICAL RECORDS, # 8 SEALED MEDICAL RECORDS, # 9 SEALED MEDICAL RECORDS) (rcb) (Entered: 09/06/2023)
09/11/2023	148	STIPULATED PROTECTIVE ORDER. Signed by JUDGE ROBERT L HINKLE on 9/11/2023. (rcb) (Entered: 09/11/2023)
09/11/2023	149	HIPAA QUALIFIED PROTECTIVE ORDER AND ORDER TO DISCLOSE PROTECTED HEALTH INFORMATION. Signed by JUDGE ROBERT L HINKLE on 9/11/2023. (rcb) (Entered: 09/11/2023)

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Doe v Ladapo: 4:23-cv-114

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE, individually and on behalf
of her minor daughter, SUSAN DOE;
BRENDA BOE, individually and on
behalf of her minor son BENNETT
BOE; CARLA COE, individually and
on behalf of her minor daughter
CHRISTINA COE; and FIONA FOE,
individually and on behalf of her minor
daughter FREYA FOE,

Civil No. _____

Plaintiffs,

v.

JOSEPH A. LADAPO, *in his official capacity*
as Florida's Surgeon General
of the Florida Department of Health;
FLORIDA BOARD OF MEDICINE;
SCOT ACKERMAN, NICHOLAS W.
ROMANELLO, Wael Barsoum,
MATTHEW R. BENSON, GREGORY
COFFMAN, AMY DERICK, DAVID
DIAMOND, PATRICK HUNTER,
LUZ MARINA PAGES, ELEONOR
PIMENTEL, HECTOR VILA,
MICHAEL WASYLIK, ZACHARIAH P.
ZACHARIAH, MARIA GARCIA,
NICOLE JUSTICE, *in their official*
capacities as members of the Florida
Board of Medicine; FLORIDA BOARD
OF OSTEOPATHIC MEDICINE;
WATSON DUCATEL, TIFFANY
SIZEMORE DI PIETRO, GREGORY
WILLIAMS, MONICA M.
MORTENSEN, VALERIE JACKSON,

CHRIS CREEGAN, WILLIAM D.
KIRSH, *in their official capacities as*
members of the Florida Board of
Osteopathic Medicine,

Defendants.

/

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF
PRELIMINARY STATEMENT¹

1. This Action is a federal constitutional challenge brought by transgender adolescents and their parents against the bans on medical care for transgender minors adopted by the Florida Boards of Medicine and Osteopathic Medicine (the “transgender medical bans”). These transgender medical bans are effective on March 16, 2023 (Board of Medicine, Rule 64B8-9.019, Fla. Admin. Code) and March 28, 2023 (Board of Osteopathic Medicine, Rule 64B15-14.014, Fla. Admin. Code).

2. The transgender medical bans violate the rights of parents to make medical decisions to ensure the health and wellbeing of their adolescent children. They prohibit parents from seeking and obtaining effective medical treatment in Florida for their adolescent children by prohibiting doctors from providing medications to adolescents in accordance with the standards of care and clinical practice guidelines for treatment of a rare and serious medical condition, gender dysphoria.

¹ Plaintiffs are filing the requisite Motions for Leave to Proceed Under Pseudonym shortly after filing the Complaint.

3. The transgender medical bans also violate the guarantees of equal protection by banning essential medical treatments needed by the adolescent Plaintiffs because they are transgender.

4. Defendants cannot demonstrate any rational basis, much less an important or compelling one, for the transgender medical bans which prevent transgender adolescents from getting safe and effective medically necessary healthcare.

5. The plaintiffs seek declaratory and injunctive relief to enjoin enforcement of the transgender medical bans. Without the relief sought, plaintiffs will suffer real and immediate injury.

PARTIES

I. Transgender Plaintiffs and Their Parents

6. Plaintiff Jane Doe is and has at all relevant times been a resident of St. Johns County, Florida. She is the mother of Plaintiff Susan Doe, an eleven-year-old transgender girl for whom she also appears in this case as next friend. Susan Doe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through her parent Jane Doe. Plaintiff Jane Doe and Plaintiff Susan Doe seek to proceed in this case under a pseudonym to protect the minor plaintiffs' right to privacy given that she is a minor and the disclosure of her identity "would reveal matters of a highly sensitive and personal nature, specifically [the minor]'s transgender status and [her]

diagnosed medical condition—gender dysphoria.” *Foster v. Andersen*, No. 18-2552-DDC-KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019). *See* Motion to Proceed Pseudonymously, filed concurrently herewith.

7. Plaintiff Brenda Boe is and has at all relevant times been a resident of Alachua County, Florida. She is the mother of Plaintiff Bennett Boe, a fourteen-year-old transgender boy for whom she also appears in this case as next friend. Bennett Boe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through his parent Brenda Boe. Plaintiff Brenda Boe and Plaintiff Bennett Boe seek to proceed in this case under a pseudonym to protect the minor plaintiffs’ right to privacy given that he is a minor and the disclosure of his identity “would reveal matters of a highly sensitive and personal nature, specifically [the minor]’s transgender status and [his] diagnosed medical condition—gender dysphoria.” *Foster v. Andersen*, No. 18-2552-DDC-KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019). *See* Motion to Proceed Pseudonymously, filed concurrently herewith.

8. Plaintiff Carla Coe is and has at all relevant times been a resident of Duval County, Florida. She is the mother of Plaintiff Christina Coe, a nine-year-old transgender girl for whom she also appears in this case as next friend. Christina Coe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through her parent Carla Coe. Plaintiff Carla Coe and Plaintiff Christina Coe seek to proceed in this case under a pseudonym to protect the minor plaintiffs’ right to privacy given that

she is a minor and the disclosure of her identity “would reveal matters of a highly sensitive and personal nature, specifically [the minor]’s transgender status and [her] diagnosed medical condition—gender dysphoria.” *Foster v. Andersen*, No. 18-2552-DDC-KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019). *See* Motion to Proceed Pseudonymously, filed concurrently herewith.

9. Plaintiff Fiona Foe is and has at all relevant times been a resident of Orange County, Florida. She is the mother of Plaintiff Freya Foe, a ten-year-old transgender girl for whom she also appears in this case as next friend. Freya Foe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through her parent Fiona Foe. Plaintiff Fiona Foe and Plaintiff Freya Foe seek to proceed in this case under a pseudonym to protect the minor plaintiffs’ right to privacy given that she is a minor and the disclosure of her identity “would reveal matters of a highly sensitive and personal nature, specifically [the minor]’s transgender status and [her] diagnosed medical condition—gender dysphoria.” *Foster v. Andersen*, No. 18-2552-DDC-KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019). *See* Motion to Proceed Pseudonymously, filed concurrently herewith.

II. Defendants

10. Defendant Joseph Ladapo is sued in his official capacity as the Surgeon General of the Florida Department of Health, which is responsible for “protect[ing] and promot[ing] the health” of all Floridians. Fla. Stat. § 20.43 (2022). The Surgeon

General is appointed by the Governor and serves at the pleasure of the Governor. Fla. Stat. § 20.43(2) (2022). Defendant Joseph Ladapo, M.D., in his official capacity as Surgeon General of the Florida Department of Health, initiated the process of the promulgation of the transgender medical bans pursuant to the authority granted by Fla. Stat. § 20.43(g) (2022), regarding the regulation of health practitioners. Defendant Joseph Ladapo's official place of business is located in Tallahassee, Leon County, Florida.

11. Defendant Scot Ackerman, M.D., is a member of the Florida Board of Medicine.

12. Defendant Nicholas W. Romanello, Esq., is a member of the Florida Board of Medicine.

13. Defendant Wael Barsoum, M.D. is a member of the Florida Board of Medicine.

14. Defendant Matthew R. Benson, M.D. is a member of the Florida Board of Medicine.

15. Defendant Gregory Coffman, M.D., is a member of the Florida Board of Medicine.

16. Defendant Amy Derick, M.D., is a member of the Florida Board of Medicine.

17. Defendant David Diamond, M.D. is a member of the Florida Board of

Medicine.

18. Defendant Patrick Hunter, M.D., is a member of the Florida Board of Medicine.

19. Defendant Luz Marina Pages, M.D., is a member of the Florida Board of Medicine.

20. Defendant Eleonor Pimentel, M.D., is a member of the Florida Board of Medicine.

21. Defendant Hector Vila M.D., is a member of the Florida Board of Medicine.

22. Defendant Michael Wasylik, M.D., is a member of the Florida Board of Medicine.

23. Defendant Zachariah P. Zachariah, M.D., is a member of the Florida Board of Medicine.

24. Defendant Maria Garcia, Esq., is a member of the Florida Board of Medicine.

25. Defendant Nicole Justice is a member of the Florida Board of Medicine.

26. Defendant Watson Ducatel, D.O., is a member of the Florida Board of Osteopathic Medicine.

27. Defendant Tiffany Sizemore Di Pietro, D.O., is a member of the Florida Board of Osteopathic Medicine.

28. Defendant Gregory Williams, D.O., is a member of the Florida Board of Osteopathic Medicine.

29. Defendant Monica M. Mortensen, D.O., is a member of the Florida Board of Osteopathic Medicine.

30. Defendant Valerie Jackson is a member of the Florida Board of Osteopathic Medicine.

31. Defendant Chris Creegan is a member of the Florida Board of Osteopathic Medicine.

32. Defendant William D. Kirsh, D.O., is a member of the Florida Board of Osteopathic Medicine.

33. The Florida Board of Medicine is made up of fifteen members who are appointed by the Governor. Fla. Stat. § 458.307(1) (2022). Defendant members of the Florida Board of Medicine, in their official capacities, each separately and independently took actions to promulgate Fla. Admin. Code 64B-9.019 pursuant to their rulemaking authority under Fla. Stat. §§ 458.309 and 458.331(1)(v) (2022). Further, Defendant members of the Florida Board of Medicine, in their official capacities, each has the authority to enforce Fla. Admin. Code 64B-9.019, including taking disciplinary action against any doctor for violating its provisions. Fla. Stat. § 456.072. The Florida Board of Medicine is based and headquartered in, and the official place of business for the Defendant members of the Florida Board of

Medicine is, Tallahassee, Leon County, Florida.

34. The Florida Board of Osteopathic Medicine is made up of seven members who are appointed by the Governor. Fla. Stat. § 459.004(1) (2022). Defendant members of the Florida Board of Osteopathic Medicine, in their official capacities, each separately and independently took actions to promulgate Fla. Admin. Code 64B15-14.014 pursuant to their rulemaking authority under Fla. Stat. §§ 459.005 and 459.015(1)(z) (2022). Further, Defendant members of the Florida Board of Osteopathic Medicine, in their official capacities, each has the authority to enforce Fla. Admin. Code 64B15-14.014, including taking disciplinary action against any doctor for violating its provisions. Fla. Stat. § 456.072. The Florida Board of Osteopathic Medicine is based and headquartered in, and the official place of business for the Defendant members of the Florida Board of Osteopathic Medicine is, Tallahassee, Leon County, Florida.

JURISDICTION AND VENUE

35. The plaintiffs seek redress for the deprivation of their rights secured by the United States Constitution. This Action is initiated pursuant to 42 U.S.C. § 1983 to enjoin the defendants from enforcing the transgender medical bans and for a declaration that the transgender medical bans violate federal law.

36. This Court has subject matter jurisdiction over the claims asserted herein pursuant to 28 U.S.C. §§ 1331 and 1343.

37. This Court has personal jurisdiction over the defendants because the defendants are domiciled in Florida and the denial of the plaintiffs' rights guaranteed by federal law arises out of and relates to the defendants' official duties in Florida.

38. Each of the defendants serve and reside in their official capacity on an agency or board for the State of Florida,. Therefore, venue is proper in this district pursuant to 28 U.S.C. § 1391(b)(1).

39. If enforced, the transgender medical bans would violate the constitutional rights of the plaintiffs in this judicial district. Therefore, venue is also proper in this district pursuant to 28 U.S.C. § 1391(b)(2).

40. Venue is proper in the Tallahassee Division of the Northern District of Florida under N.D. Fla. Loc. R. 3.1(B) because it is the location of the principal place of business for the defendants and where a substantial portion of the acts or omissions complained of herein occurred.

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

FACTUAL ALLEGATIONS

I. Gender Identity and Gender Dysphoria

42. Gender identity is an innate, internal sense of one's sex and is an immutable aspect of a person's identity. It is an essential element of human identity

and a well-established concept in medicine. Everyone has a gender identity. Most people's gender identity is consistent with their birth sex. Transgender people, however, have a gender identity that differs from their birth sex. Being made to live inconsistent with a person's gender identity causes discomfort and distress and can interfere with a person's ability to function in a productive and healthy way in matters of daily living.

43. Gender dysphoria is the clinical diagnosis for the distress that arises when a transgender person cannot live consistent with their gender identity. To be eligible for a diagnosis of gender dysphoria, a young person must meet the criteria set forth in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (the "DSM-5").² If left untreated, gender dysphoria can cause anxiety, depression, and self-harm, including suicidality.

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

² Earlier editions of the DSM included a diagnosis referred to as "Gender Identity Disorder." The DSM-5 noted that Gender Dysphoria "is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity *per se*. Being diagnosed with gender dysphoria "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities." Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender & Gender Variant Individuals* (2012).

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

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

47. The standards of care for treatment of transgender people, including transgender youth, were initially developed by the World Professional Association for Transgender Health ("WPATH"), an international, multidisciplinary, professional association of medical providers, mental health providers, researchers, and others, with a mission of promoting evidence-based care and research for transgender health, including the treatment of gender dysphoria. WPATH published

the most recent edition of its standards of care for the treatment of gender dysphoria in minors and adults in 2022, Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. (Coleman E, Radix AE, Bouman WP et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. Int J Transgend 2022 Sep 6;23 (suppl 1): S1-S259.)

48. The Endocrine Society has also promulgated a standard of care and clinical practice guidelines for the provision of hormone therapy as a treatment for gender dysphoria in minors and adults. *See* Wylie C. Hembree, et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. Clin. Endocrinol. Metab. 3869 (2017).

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

50. The treatment of gender dysphoria is designed to reduce a transgender person's clinically significant distress by permitting them to live in alignment with their gender identity. Undergoing treatment for gender dysphoria is commonly referred to as "transition," "gender transition," or "gender affirming care." There are

several components to the gender transition process.

51. The precise treatment of gender dysphoria depends on an individualized assessment of a patient's needs.

52. Social transition involves a transgender person taking measures to live in accordance with their gender identity in all aspects of life. For transgender boys, it means living fully as a boy; for transgender girls, it means living fully as a girl. Social transition can include adopting a name, pronouns, hairstyle, and clothing consistent with that person's gender identity. The steps a transgender person takes as part of their social transition help align their gender identity with all aspects of everyday life.

53. Gender transition may also involve taking prescribed medications, puberty blockers and hormones, to bring a person's body into alignment with their gender identity.

54. There are no medications prescribed to transgender children before they have begun puberty.

55. For a transgender adolescent who has begun puberty, puberty-blocking medication prevents the patient from going through the physical developments associated with puberty that exacerbate the distress experienced by the incongruence between the patient's gender identity and their body. As such, under the WPATH Standards of Care and clinical practice guidelines, puberty-blocking medication may

become medically necessary and appropriate after a transgender adolescent reaches puberty to minimize or prevent the exacerbation of gender dysphoria and the permanent physical changes that puberty would cause. In providing medical treatments to adolescents, pediatric physicians and endocrinologists work in close consultation with qualified mental health professionals experienced in the diagnosis and treatment of gender dysphoria.

56. For older transgender adolescents, hormone therapy may also be medically necessary to bring their body into alignment with their gender identity and further treat the gender dysphoria they may experience without treatment.

57. The treatment for gender dysphoria is highly effective. Longitudinal studies have shown that transgender children with gender dysphoria who receive essential medical care, including puberty blockers and hormones, show levels of mental health and stability consistent with those of non-transgender children. Lily Durwood, et al., *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*, 56 J. Am. Acad. Child & Adolescent Psychiatry 116 (2017); Kristina Olson, et al., *Mental Health of Transgender Children Who are Supported in Their Identities*, 137 Pediatrics 1 (2016). In contrast, transgender children with gender dysphoria who do not receive appropriate medical care are at risk of serious harm, including dramatically increased rates of suicidality and serious depression.

II. The Transgender Medical Bans

58. On June 2, 2022, Defendant Joseph A. Ladapo sent a letter to the Florida Board of Medicine and the Florida Board of Osteopathic Medicine (collectively, the “Boards”) asking the Boards to “establish a standard of care” for the treatment of gender dysphoria, notwithstanding the widely accepted standards of care and clinical practice guidelines established by WPATH and the Endocrine Society.

59. On July 28, 2022, the Florida Department of Health sent the Boards a “Petition to Initiate Rulemaking,” asking the Board, among other things, to adopt a categorical ban on all treatment of gender dysphoria for people under eighteen years of age.

60. On August 5, 2022, the Boards discussed the June 2, 2022 letter from Dr. Lapado and the July 28, 2022 Petition to Initiate Rulemaking. The Boards voted to accept the Petition to Initiate Rulemaking.

61. On September 1, 2022, the Boards each published a Notice of Development of Rulemaking in the Florida Administrative Register (F.A.R.), proposing “rule development to clarify the practice standards for treatment of gender dysphoria in minors.”

62. On October 14, 2022, the Boards each published a Notice of Rule Workshop, which would take place on October 28, 2022.

63. On October 28, 2022, the Boards held a Joint Workshop regarding the

development of a rule related to “Practice Standards for the Treatment of Gender Dysphoria.” At the conclusion of the meeting, the Boards voted in support of proposed rules that would ban puberty blockers and hormones, with an exception for treatment performed as clinical trials under the auspices of the Institutional Review Board (the “exception”). The proposed rules were as follows:

- (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) Nonsurgical treatments for the treatment of gender dysphoria in minors may continue to be performed under the auspices of Institutional Review Board (IRB) approved, investigator-initiated clinical trials conducted at any of the Florida medical schools set forth in Section 458.3145(1)(i), Florida Statutes. Such clinical trials must include long term longitudinal assessments of the patients’ physiologic and psychologic outcomes.
- (3) Minors being treated with puberty blocking, hormone, or hormone antagonist therapies prior to the effective date of this rule may continue with such therapies.

64. On November 4, 2022, the Florida Board of Medicine voted to remove the exception from its proposed transgender medical ban.

65. On January 9, 2023, the Boards published Notices of Public Hearing in the Florida Administrative Register, regarding a joint hearing of the Boards scheduled to take place on February 10, 2023.

66. On February 10, 2023, during the Public Hearing, the Florida Board of Osteopathic Medicine voted to remove the exception from its proposed transgender

medical bans.

67. The Florida Board of Medicine filed the following rule with the Florida Department of State on February 24, 2023, with an effective date of March 16, 2023:

- (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.

68. The Florida Board of Osteopathic Medicine filed the following rule with the Florida Department of State on March 8, 2023, with an effective date of March 28, 2023:

- (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.

69. The transgender medical bans include a clause that permits minors being treated with puberty blockers or hormones prior to the effective date of the transgender medical bans to continue to receive those treatments.

70. For any transgender minor who is not yet receiving puberty blockers or hormones at the effective date of the transgender medical bans, they will not be able to obtain such treatment from a Florida doctor regardless of medical necessity.

71. The transgender medical bans ignore the established medical and scientific consensus that these treatments are medically necessary, safe, and effective for the treatment of gender dysphoria.

72. The transgender medical bans are in direct conflict with state laws ensuring that parents have the right to make medical decisions for their adolescent children. *See* Florida Statutes 1014.02 (which provides that “it is a fundamental right of parents to direct the upbringing, education, and care of their minor children.”); Florida Statutes 1014.03 (“The state, any of its political subdivisions, any other governmental entity, or any other institution *may not infringe on the fundamental rights of a parent to direct* the upbringing, education, *health care*, and mental health of his or her minor child[.]”) (emphasis added).

III. The Transgender Medical Bans Will Irreparably Harm the Plaintiffs

Jane Doe and her daughter Susan Doe

73. Susan Doe is an eleven-year-old transgender girl who resides with her mother, Jane Doe, her father, and her three siblings in St. Johns County, Florida.

74. From an early age, Susan began telling her parents that she is a girl. She began living fully as a girl, with the support of her family and upon advice of her

pediatrician by the time she started kindergarten.

75. Susan has been diagnosed with gender dysphoria and that diagnosis has been confirmed by many doctors, including her doctor at the Pentagon. Susan has not been prescribed puberty blockers or hormones to treat her gender dysphoria.

76. Susan's medical providers, including her pediatrician, pediatric endocrinologist, and medical provider on base, continue to monitor her treatment and concluded that it likely will be medically necessary for her to begin puberty blocking medications after she begins puberty, which is imminent. The transgender medical bans, however, will prevent her from obtaining treatment.

Brenda Boe and her son Bennett Boe

77. Bennett Boe is a fourteen-year-old transgender boy who resides in Alachua County, Florida, with his mother, Brenda Boe.

78. Bennett has known that he was not a girl since the third grade. After he began puberty and started experiencing the accompanying physical changes, Bennett grew increasingly distressed by the mismatch between his body and his sense of himself as a boy. Around that time, Bennett experienced debilitating depression, culminating in an incident of self-harm resulting in hospitalization.

79. Bennett's mother Brenda took Bennett to see medical professionals who diagnosed Bennett with gender dysphoria and recommended treatment, including menstrual suppression medication. With Brenda's consent, Bennett began

treatment which has considerably alleviated his depression.

80. Even with that treatment, Bennett continues to experience gender dysphoria as a result of continued pubertal development inconsistent with his sense of himself as a boy.

81. Bennett's doctors believe it may be medically necessary for him to begin hormone therapy after he turns sixteen.

82. Brenda and Bennett fear that the transgender medical medical bans will prevent him from being able to treat his ongoing symptoms of gender dysphoria with hormone therapy.

Carla Coe and her daughter Christina Coe

83. Christina Coe is a nine-year-old transgender girl, and one of three triplets, who resides in Duval County, Florida with her mother, Carla Coe, her father, and her siblings.

84. From an early age, Christina began to say to her parents that she is a girl.

85. At age five Christina began to express distress including suicidal ideation and a desire to harm herself.

86. Since entering the third grade, Christina has been living as a girl in all aspects of her life. She has not expressed a renewed desire to harm herself.

87. Carla and her husband fear that Christina will not be able to get the

medical care she needs after she begins puberty because of the transgender medical bans.

Fiona Foe and her daughter Freya Foe

88. Freya Foe is a ten-year-old transgender girl who resides with her mother, Fiona Foe, her father, her grandmother, and her two siblings in Orange County, Florida.

89. As soon as she could walk and talk, Freya was very feminine in her self expression, including her choices of clothing and toys.

90. As she grew older, Freya began to express distress about being seen as a boy. Fiona and her husband took Freya to see a psychologist who diagnosed her with gender dysphoria.

91. Shortly before her tenth birthday, Freya's doctor examined her and determined that she had reached Tanner Stage 2, meaning puberty is in progress. In the months preceding this examination, Freya had begun to express distress about the onset of puberty and her performance in school began to decline.

92. In December 2022, Freya's doctors determined that puberty blocking medication was medically necessary for the treatment of her gender dysphoria. With the consent of her parents, Freya began puberty blocking medication. Since then, Freya's overall wellbeing and performance in school have improved.

93. The transgender medical bans will prevent Freya's medical providers

from prescribing hormones to allow her to go through female puberty, medication she may need as her peers continue to develop through puberty.

CLAIMS FOR RELIEF

COUNT I

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

94. The plaintiffs incorporate all preceding paragraphs of the Complaint as if set forth fully herein.

95. The parent plaintiffs bring this Count against all the defendants.

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

97. The transgender medical bans violate this fundamental right by preventing the parent plaintiffs from obtaining medically necessary care for their minor adolescent children.

98. By intruding upon parents’ fundamental right to direct the upbringing

of their adolescent children, the transgender medical bans are subject to strict scrutiny.

99. The defendants have no compelling justification for preventing parents from ensuring their adolescent children can receive essential medical care. The transgender medical bans do not advance any legitimate interest, much less a compelling one.

COUNT II
Deprivation of Equal Protection
All Plaintiffs Against Defendants in Their Official Capacities
U.S. Const. Amend. XIV

100. The plaintiffs incorporate Paragraphs 1–93 of the Complaint as if set forth fully herein.

101. All the plaintiffs bring this Count against all the defendants.

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

103. The transgender medical bans single out transgender minors and prohibit them from obtaining medically necessary treatment based on their sex and transgender status.

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

105. Transgender-based government classifications are subject to heightened scrutiny because they are sex-based classifications.

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

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

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

109. The transgender medical bans are not narrowly tailored to further a compelling government interest, substantially related to any important governmental interest, or even rationally related to a governmental interest. Accordingly, the transgender medical bans violate the Equal Protection Clause of the Fourteenth Amendment.

RELIEF REQUESTED

WHEREFORE, the plaintiffs request that this Court:

(1) issue a judgment, pursuant to 28 U.S.C. §§ 2201-2202, declaring that the

- transgender medical bans violate the United States Constitution for the reasons and on the Counts set forth above;
- (2) temporarily, preliminarily, and permanently enjoin the defendants and their officers, employees, servants, agents, appointees, or successors from enforcing the transgender medical bans;
- (3) declare that the transgender medical bans violate the Fourteenth Amendment to the United States Constitution;
- (4) award the plaintiffs their costs and attorneys' fees pursuant to 42 U.S.C. § 1988 and other applicable laws; and
- (5) grant such other relief as the Court finds just and proper.

Respectfully submitted this 23rd day of March, 2023.

By: /s/ Lawrence Silverman

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Florida Bar No. 119324

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pending

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Ami Patel* (CA No. 325647)

Jason Starr* (NY No. 5005194)

NATIONAL CENTER FOR LESBIAN RIGHTS

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pro hac vice forthcoming

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The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)

I. (a) PLAINTIFFS

Doe, Jane, individually and on behalf of her minor

(b) County of Residence of First Listed Plaintiff **St. Johns**
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys (Firm Name, Address, and Telephone Number)

Lawrence Silverman

lawrence.silverman@sidley.com

DEFENDANTS

Fla. Dep't of Health, Ladapo, Joseph A., Surgeon General;

County of Residence of First Listed Defendant
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF
THE TRACT OF LAND INVOLVED.

Attorneys (If Known)

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

- ☐ 1 U.S. Government Plaintiff ☐ 3 Federal Question (U.S. Government Not a Party)
- ☐ 2 U.S. Government Defendant ☐ 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated or Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated and Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT (Place an "X" in One Box Only)Click here for: [Nature of Suit Code Descriptions.](#)

CONTRACT	TORTS	FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
☐ 110 Insurance ☐ 120 Marine ☐ 130 Miller Act ☐ 140 Negotiable Instrument ☐ 150 Recovery of Overpayment & Enforcement of Judgment ☐ 151 Medicare Act ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans) ☐ 153 Recovery of Overpayment of Veteran's Benefits ☐ 160 Stockholders' Suits ☐ 190 Other Contract ☐ 195 Contract Product Liability ☐ 196 Franchise	PERSONAL INJURY ☐ 310 Airplane ☐ 315 Airplane Product Liability ☐ 320 Assault, Libel & Slander ☐ 330 Federal Employers' Liability ☐ 340 Marine ☐ 345 Marine Product Liability ☐ 350 Motor Vehicle ☐ 355 Motor Vehicle Product Liability ☐ 360 Other Personal Injury ☐ 362 Personal Injury - Medical Malpractice PERSONAL INJURY ☐ 365 Personal Injury - Product Liability ☐ 367 Health Care/Pharmaceutical Personal Injury Product Liability ☐ 368 Asbestos Personal Injury Product Liability PERSONAL PROPERTY ☐ 370 Other Fraud ☐ 371 Truth in Lending ☐ 380 Other Personal Property Damage ☐ 385 Property Damage Product Liability	☐ 625 Drug Related Seizure of Property 21 USC 881 ☐ 690 Other LABOR ☐ 710 Fair Labor Standards Act ☐ 720 Labor/Management Relations ☐ 740 Railway Labor Act ☐ 751 Family and Medical Leave Act ☐ 790 Other Labor Litigation ☐ 791 Employee Retirement Income Security Act IMMIGRATION ☐ 462 Naturalization Application ☐ 465 Other Immigration Actions	☐ 422 Appeal 28 USC 158 ☐ 423 Withdrawal 28 USC 157 INTELLECTUAL PROPERTY RIGHTS ☐ 820 Copyrights ☐ 830 Patent ☐ 835 Patent - Abbreviated New Drug Application ☐ 840 Trademark ☐ 880 Defend Trade Secrets Act of 2016 SOCIAL SECURITY ☐ 861 HIA (1395ff) ☐ 862 Black Lung (923) ☐ 863 DIWC/DIWW (405(g)) ☐ 864 SSID Title XVI ☐ 865 RSI (405(g)) FEDERAL TAX SUITS ☐ 870 Taxes (U.S. Plaintiff or Defendant) ☐ 871 IRS—Third Party 26 USC 7609	☐ 375 False Claims Act ☐ 376 Qui Tam (31 USC 3729(a)) ☐ 400 State Reapportionment ☐ 410 Antitrust ☐ 430 Banks and Banking ☐ 450 Commerce ☐ 460 Deportation ☐ 470 Racketeer Influenced and Corrupt Organizations ☐ 480 Consumer Credit (15 USC 1681 or 1692) ☐ 485 Telephone Consumer Protection Act ☐ 490 Cable/Sat TV ☐ 850 Securities/Commodities/Exchange ☐ 890 Other Statutory Actions ☐ 891 Agricultural Acts ☐ 893 Environmental Matters ☐ 895 Freedom of Information Act ☐ 896 Arbitration ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision ☐ 950 Constitutionality of State Statutes
REAL PROPERTY ☐ 210 Land Condemnation ☐ 220 Foreclosure ☐ 230 Rent Lease & Ejectment ☐ 240 Torts to Land ☐ 245 Tort Product Liability ☐ 290 All Other Real Property	CIVIL RIGHTS ☐ 440 Other Civil Rights ☐ 441 Voting ☐ 442 Employment ☐ 443 Housing/Accommodations ☐ 445 Amer. w/Disabilities - Employment ☐ 446 Amer. w/Disabilities - Other ☐ 448 Education PRISONER PETITIONS Habeas Corpus: ☐ 463 Alien Detainee ☐ 510 Motions to Vacate Sentence ☐ 530 General ☐ 535 Death Penalty Other: ☐ 540 Mandamus & Other ☐ 550 Civil Rights ☐ 555 Prison Condition ☐ 560 Civil Detainee - Conditions of Confinement			

V. ORIGIN (Place an "X" in One Box Only)

- ☐ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District (specify) ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTIONCite the U.S. Civil Statute under which you are filing (Do not cite jurisdictional statutes unless diversity):
42 U.S.C. § 1983Brief description of cause:
Deprivation of substantive due process and equal protection.**VII. REQUESTED IN COMPLAINT:**☐ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.**DEMAND \$**

Preliminary injunction

CHECK YES only if demanded in complaint:

JURY DEMAND:☐ Yes ☐ No**VIII. RELATED CASE(S) IF ANY**

(See instructions):

JUDGE

DOCKET NUMBER

DATE

Mar 23, 2023

SIGNATURE OF ATTORNEY OF RECORD

/s/ Lawrence D. Silverman

FOR OFFICE USE ONLY

RECEIPT # AMOUNT APPLYING IFP JUDGE MAG. JUDGE

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

- I. (a) **Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.
 - (b) **County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)
 - (c) **Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".
- II. **Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
- United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here. United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
- Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
- Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below; **NOTE: federal question actions take precedence over diversity cases.**)
- III. **Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.
- IV. **Nature of Suit.** Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: [Nature of Suit Code Descriptions](#).
- V. **Origin.** Place an "X" in one of the seven boxes.
- Original Proceedings. (1) Cases which originate in the United States district courts.
- Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
- Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
- Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
- Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
- Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
- Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
- PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7.** Origin Code 7 was used for historical records and is no longer relevant due to changes in statute.
- VI. **Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service.
- VII. **Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
- Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
- Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.
- VIII. **Related Cases.** This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.

Doc. 29

Doe v Ladapo: 4:23-cv-114

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

JANE DOE, individually and on behalf
of her minor daughter, SUSAN DOE;
BRENDA BOE, individually and on
behalf of her minor son BENNETT
BOE; CARLA COE, individually and
on behalf of her minor daughter
CHRISTINA COE; FIONA FOE,
individually and on behalf of her minor
daughter FREYA FOE; GLORIA GOE,
individually and on behalf of her minor
son GAVIN GOE; and LINDA LOE,
individually and on behalf of her minor
daughter LISA LOE; PATRICIA POE,
individually and on behalf of her minor
son PAUL POE,

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;
FLORIDA BOARD OF MEDICINE;
SCOT ACKERMAN, NICHOLAS W.
ROMANELLO, Wael Barsoum,
MATTHEW R. BENSON, GREGORY
COFFMAN, AMY DERICK, DAVID
DIAMOND, PATRICK HUNTER,
LUZ MARINA PAGES, ELEONOR
PIMENTEL, HECTOR VILA,
MICHAEL WASYLIK, ZACHARIAH P.
ZACHARIAH, MARIA GARCIA,
NICOLE JUSTICE, *in their official*
capacities as members of the Florida

*Board of Medicine; FLORIDA BOARD
OF OSTEOPATHIC MEDICINE;
WATSON DUCATEL, TIFFANY
SIZEMORE DI PIETRO, GREGORY
WILLIAMS, MONICA M.
MORTENSEN, VALERIE JACKSON,
CHRIS CREEGAN, WILLIAM D.
KIRSH, in their official capacities as
members of the Florida Board of
Osteopathic Medicine,*

Defendants.

/

**FIRST AMENDED COMPLAINT FOR DECLARATORY AND
INJUNCTIVE RELIEF**

PRELIMINARY STATEMENT¹

1. This Action is a federal constitutional challenge brought by transgender adolescents and their parents against the bans on medical care for transgender minors adopted by the Florida Boards of Medicine and Osteopathic Medicine (the “transgender medical bans”). These transgender medical bans are effective as of March 16, 2023 (Board of Medicine, Rule 64B8-9.019, Fla. Admin. Code) and March 28, 2023 (Board of Osteopathic Medicine, Rule 64B15-14.014, Fla. Admin. Code).

2. The transgender medical bans violate the rights of parents to make

¹ Plaintiffs Goe, Loe, and Poe are filing the requisite Motions for Leave to Proceed Under Pseudonym shortly after filing the Complaint.

medical decisions to ensure the health and wellbeing of their adolescent children. They prohibit parents from seeking and obtaining effective medical treatment in Florida for their adolescent children by prohibiting doctors from providing medications to adolescents in accordance with the standards of care and clinical practice guidelines for treatment of a rare and serious medical condition, gender dysphoria.

3. The transgender medical bans also violate the guarantees of equal protection by banning essential medical treatments needed by the adolescent Plaintiffs because they are transgender.

4. Defendants cannot demonstrate any rational basis, much less an important or compelling one, for the transgender medical bans which prevent transgender adolescents from getting safe and effective medically necessary healthcare.

5. The plaintiffs seek declaratory and injunctive relief to enjoin enforcement of the transgender medical bans. Without the relief sought, plaintiffs will suffer real and immediate injury.

PARTIES

I. Transgender Plaintiffs and Their Parents

6. Plaintiff Jane Doe is and has at all relevant times been a resident of St. Johns County, Florida. She is the mother of Plaintiff Susan Doe, an eleven-year-old

transgender girl for whom she also appears in this case as next friend. Susan Doe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through her parent Jane Doe. Plaintiff Jane Doe and Plaintiff Susan Doe seek to proceed in this case under a pseudonym to protect the minor plaintiff's right to privacy given that she is a minor and the disclosure of her identity "would reveal matters of a highly sensitive and personal nature, specifically [the minor]'s transgender status and [her] diagnosed medical condition—gender dysphoria." *Foster v. Andersen*, No. 18-2552-DDC-KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019). *See* Motion to Proceed Pseudonymously, filed on April 6, 2023, ECF 21.

7. Plaintiff Brenda Boe is and has at all relevant times been a resident of Alachua County, Florida. She is the mother of Plaintiff Bennett Boe, a fourteen-year-old transgender boy for whom she also appears in this case as next friend. Bennett Boe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through his parent Brenda Boe. Plaintiff Brenda Boe and Plaintiff Bennett Boe seek to proceed in this case under a pseudonym to protect the minor plaintiff's right to privacy given that he is a minor and the disclosure of his identity "would reveal matters of a highly sensitive and personal nature, specifically [the minor]'s transgender status and his diagnosed medical condition—gender dysphoria." *Foster v. Andersen*, No. 18-2552-DDC-KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019). *See* Motion to Proceed Pseudonymously, filed on April 6, 2023, ECF 19.

8. Plaintiff Carla Coe is and has at all relevant times been a resident of Duval County, Florida. She is the mother of Plaintiff Christina Coe, a nine-year-old transgender girl for whom she also appears in this case as next friend. Christina Coe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through her parent Carla Coe. Plaintiff Carla Coe and Plaintiff Christina Coe seek to proceed in this case under a pseudonym to protect the minor plaintiff's right to privacy given that she is a minor and the disclosure of her identity "would reveal matters of a highly sensitive and personal nature, specifically [the minor]'s transgender status and [her] diagnosed medical condition—gender dysphoria." *Foster v. Andersen*, No. 18-2552-DDC-KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019). *See* Motion to Proceed Pseudonymously, filed on April 6, 2023, ECF 20.

9. Plaintiff Fiona Foe is and has at all relevant times been a resident of Orange County, Florida. She is the mother of Plaintiff Freya Foe, a ten-year-old transgender girl for whom she also appears in this case as next friend. Freya Foe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through her parent Fiona Foe. Plaintiff Fiona Foe and Plaintiff Freya Foe seek to proceed in this case under a pseudonym to protect the minor plaintiff's right to privacy given that she is a minor and the disclosure of her identity "would reveal matters of a highly sensitive and personal nature, specifically [the minor]'s transgender status and [her] diagnosed medical condition—gender dysphoria." *Foster v. Andersen*, No. 18-2552-DDC-

KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019). *See* Motion to Proceed Pseudonymously, filed on April 6, 2023, ECF 22.

10. Plaintiff Gloria Goe is and has at all relevant times been a resident of Lee County, Florida. She is the mother of Gavin Goe, an eight-year-old transgender boy for whom she also appears in this case as next friend. Gavin Goe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through his parent Gloria Goe. Plaintiff Gloria Goe and Plaintiff Gavin Goe seek to proceed in this case under a pseudonym to protect the minor plaintiff's right to privacy given that he is a minor and the disclosure of his identity "would reveal matters of a highly sensitive and personal nature, specifically [the minor]'s transgender status and his diagnosed medical condition—gender dysphoria." *Foster v. Andersen*, No. 18-2552-DDC-KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019). *See* Motion to Proceed Pseudonymously, filed concurrently herewith.

11. Plaintiff Linda Loe is and has at all relevant times been a resident of Miami-Dade County, Florida. She is the mother of Lisa Loe, an eleven-year-old transgender girl for whom she also appears in this case as next friend. Lisa Loe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through her parent Linda Loe. Plaintiff Linda Loe and Plaintiff Lisa Loe seek to proceed in this case under a pseudonym to protect the minor plaintiff's right to privacy given that she is a minor and the disclosure of her identity "would reveal matters of a highly sensitive and

personal nature, specifically [the minor]’s transgender status and [her] diagnosed medical condition—gender dysphoria.” *Foster v. Andersen*, No. 18-2552-DDC-KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019). *See* Motion to Proceed Pseudonymously, filed concurrently herewith.

12. Plaintiff Patricia Poe is and has at all relevant times been a resident of Miami-Dade County, Florida. She is the mother of Paul Poe, a nine-year-old transgender boy for whom she also appears in this case as next friend. Paul Poe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through his parent Patricia Poe. Plaintiff Patricia Poe and Plaintiff Paul Poe seek to proceed in this case under a pseudonym to protect the minor plaintiff’s right to privacy given that he is a minor and the disclosure of his identity “would reveal matters of a highly sensitive and personal nature, specifically [the minor]’s transgender status and his diagnosed medical condition—gender dysphoria.” *Foster v. Andersen*, No. 18-2552-DDC-KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019). *See* Motion to Proceed Pseudonymously, filed concurrently herewith.

II. Defendants

13. Defendant Joseph Ladapo, M.D., is sued in his official capacity as the Surgeon General of the Florida Department of Health, which is responsible for “protect[ing] and promot[ing] the health” of all Floridians. Fla. Stat. § 20.43 (2022). The Surgeon General is appointed by the Governor and serves at the pleasure of the

Governor. Fla. Stat. § 20.43(2) (2022). Defendant Ladapo, in his official capacity as Surgeon General of the Florida Department of Health, initiated the process of the promulgation of the transgender medical bans pursuant to the authority granted by Fla. Stat. § 20.43(g) (2022), regarding the regulation of health practitioners. Defendant Ladapo's official place of business is located in Tallahassee, Leon County, Florida.

14. Defendant Scot Ackerman, M.D., is a member of the Florida Board of Medicine.

15. Defendant Nicholas W. Romanello, Esq., is a member of the Florida Board of Medicine.

16. Defendant Wael Barsoum, M.D., is a member of the Florida Board of Medicine.

17. Defendant Matthew R. Benson, M.D., is a member of the Florida Board of Medicine.

18. Defendant Gregory Coffman, M.D., is a member of the Florida Board of Medicine.

19. Defendant Amy Derick, M.D., is a member of the Florida Board of Medicine.

20. Defendant David Diamond, M.D., is a member of the Florida Board of Medicine.

21. Defendant Patrick Hunter, M.D., is a member of the Florida Board of Medicine.

22. Defendant Luz Marina Pages, M.D., is a member of the Florida Board of Medicine.

23. Defendant Eleonor Pimentel, M.D., is a member of the Florida Board of Medicine.

24. Defendant Hector Vila M.D., is a member of the Florida Board of Medicine.

25. Defendant Michael Wasylik, M.D., is a member of the Florida Board of Medicine.

26. Defendant Zachariah P. Zachariah, M.D., is a member of the Florida Board of Medicine.

27. Defendant Maria Garcia, Esq., is a member of the Florida Board of Medicine.

28. Defendant Nicole Justice is a member of the Florida Board of Medicine.

29. Defendant Watson Ducatel, D.O., is a member of the Florida Board of Osteopathic Medicine.

30. Defendant Tiffany Sizemore Di Pietro, D.O., is a member of the Florida Board of Osteopathic Medicine.

31. Defendant Gregory Williams, D.O., is a member of the Florida Board

of Osteopathic Medicine.

32. Defendant Monica M. Mortensen, D.O., is a member of the Florida Board of Osteopathic Medicine.

33. Defendant Valerie Jackson is a member of the Florida Board of Osteopathic Medicine.

34. Defendant Chris Creegan is a member of the Florida Board of Osteopathic Medicine.

35. Defendant William D. Kirsh, D.O., is a member of the Florida Board of Osteopathic Medicine.

36. The Florida Board of Medicine is made up of fifteen members who are appointed by the Governor. Fla. Stat. § 458.307(1) (2022). Defendant members of the Florida Board of Medicine, in their official capacities, each separately and independently took actions to promulgate Fla. Admin. Code 64B-9.019 pursuant to their rulemaking authority under Fla. Stat. §§ 458.309 and 458.331(1)(v) (2022). Further, Defendant members of the Florida Board of Medicine, in their official capacities, each has the authority to enforce Fla. Admin. Code 64B-9.019, including taking disciplinary action against any doctor for violating its provisions. Fla. Stat. § 456.072. The Florida Board of Medicine is based and headquartered in, and the official place of business for the Defendant members of the Florida Board of Medicine is, Tallahassee, Leon County, Florida.

37. The Florida Board of Osteopathic Medicine is made up of seven members who are appointed by the Governor. Fla. Stat. § 459.004(1) (2022). Defendant members of the Florida Board of Osteopathic Medicine, in their official capacities, each separately and independently took actions to promulgate Fla. Admin. Code 64B15-14.014 pursuant to their rulemaking authority under Fla. Stat. §§ 459.005 and 459.015(1)(z) (2022). Further, Defendant members of the Florida Board of Osteopathic Medicine, in their official capacities, each has the authority to enforce Fla. Admin. Code 64B15-14.014, including taking disciplinary action against any doctor for violating its provisions. Fla. Stat. § 456.072. The Florida Board of Osteopathic Medicine is based and headquartered in, and the official place of business for the Defendant members of the Florida Board of Osteopathic Medicine is, Tallahassee, Leon County, Florida.

JURISDICTION AND VENUE

38. The plaintiffs seek redress for the deprivation of their rights secured by the United States Constitution. This Action is initiated pursuant to 42 U.S.C. § 1983 to enjoin the defendants from enforcing the transgender medical bans and for a declaration that the transgender medical bans violate federal law.

39. This Court has subject matter jurisdiction over the claims asserted herein pursuant to 28 U.S.C. §§ 1331 and 1343.

40. This Court has personal jurisdiction over the defendants because the

defendants are domiciled in Florida and the denial of the plaintiffs' rights guaranteed by federal law arises out of and relates to the defendants' official duties in Florida.

41. Each of the defendants serve and reside in their official capacity on an agency or board for the State of Florida. Therefore, venue is proper in this district pursuant to 28 U.S.C. § 1391(b)(1).

42. If enforced, the transgender medical bans would violate the constitutional rights of the plaintiffs in this judicial district. Therefore, venue is also proper in this district pursuant to 28 U.S.C. § 1391(b)(2).

43. Venue is proper in the Tallahassee Division of the Northern District of Florida under N.D. Fla. Loc. R. 3.1(B) because it is the location of the principal place of business for the defendants and where a substantial portion of the acts or omissions complained of herein occurred.

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

FACTUAL ALLEGATIONS

I. Gender Identity and Gender Dysphoria

45. Gender identity is an innate, internal sense of one's sex and is an immutable aspect of a person's identity. It is an essential element of human identity and a well-established concept in medicine. Everyone has a gender identity. Most

people's gender identity is consistent with their birth sex. Transgender people, however, have a gender identity that differs from their birth sex. Being made to live inconsistent with a person's gender identity causes discomfort and distress and can interfere with a person's ability to function in a productive and healthy way in matters of daily living.

46. Gender dysphoria is the clinical diagnosis for the distress that arises when a transgender person cannot live consistent with their gender identity. To be eligible for a diagnosis of gender dysphoria, a young person must meet the criteria set forth in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (the "DSM-5").² If left untreated, gender dysphoria can cause anxiety, depression, and self-harm, including suicidality.

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

48. Research has shown that an individual's gender identity is hard-wired

² Earlier editions of the DSM included a diagnosis referred to as "Gender Identity Disorder." The DSM-5 noted that Gender Dysphoria "is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity *per se*. Being diagnosed with gender dysphoria "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities." Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender & Gender Variant Individuals* (2012).

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

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

50. The standards of care for treatment of transgender people, including transgender youth, were initially developed by the World Professional Association for Transgender Health ("WPATH"), an international, multidisciplinary, professional association of medical providers, mental health providers, researchers, and others, with a mission of promoting evidence-based care and research for transgender health, including the treatment of gender dysphoria. WPATH published the most recent edition of its standards of care for the treatment of gender dysphoria

in minors and adults in 2022, Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. (Coleman E, Radix AE, Bouman WP et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. Int J Transgend 2022 Sep 6;23 (suppl 1): S1-S259.)

51. The Endocrine Society has also promulgated a standard of care and clinical practice guidelines for the provision of hormone therapy as a treatment for gender dysphoria in minors and adults. See Wylie C. Hembree, et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. Clin. Endocrinol. Metab. 3869 (2017).

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

53. The treatment of gender dysphoria is designed to reduce a transgender person's clinically significant distress by permitting them to live in alignment with their gender identity. Undergoing treatment for gender dysphoria is commonly referred to as "transition," "gender transition," or "gender affirming care." There are several components to the gender transition process.

54. The precise treatment of gender dysphoria depends on an individualized assessment of a patient's needs.

55. Social transition involves a transgender person taking measures to live in accordance with their gender identity in all aspects of life. For transgender boys, it means living fully as a boy; for transgender girls, it means living fully as a girl. Social transition can include adopting a name, pronouns, hairstyle, and clothing consistent with that person's gender identity. The steps a transgender person takes as part of their social transition help align their gender identity with all aspects of everyday life.

56. Gender transition may also involve taking prescribed medications, puberty blockers and hormones, to bring a person's body into alignment with their gender identity.

57. There are no medications prescribed to transgender children before they have begun puberty.

58. For a transgender adolescent who has begun puberty, puberty-blocking medication prevents the patient from going through the physical developments associated with puberty that exacerbate the distress experienced by the incongruence between the patient's gender identity and their body. As such, under the WPATH Standards of Care and clinical practice guidelines, puberty-blocking medication may become medically necessary and appropriate after a transgender adolescent reaches

puberty to minimize or prevent the exacerbation of gender dysphoria and the permanent physical changes that puberty would cause. In providing medical treatments to adolescents, pediatric physicians and endocrinologists work in close consultation with qualified mental health professionals experienced in the diagnosis and treatment of gender dysphoria.

59. For older transgender adolescents, hormone therapy may also be medically necessary to bring their body into alignment with their gender identity and further treat the gender dysphoria they may experience without treatment.

60. The treatment for gender dysphoria is highly effective. Longitudinal studies have shown that transgender children with gender dysphoria who receive essential medical care, including puberty blockers and hormones, show levels of mental health and stability consistent with those of non-transgender children. Lily Durwood, et al., *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*, 56 J. Am. Acad. Child & Adolescent Psychiatry 116 (2017); Kristina Olson, et al., *Mental Health of Transgender Children Who are Supported in Their Identities*, 137 Pediatrics 1 (2016). In contrast, transgender children with gender dysphoria who do not receive appropriate medical care are at risk of serious harm, including dramatically increased rates of suicidality and serious depression.

II. The Transgender Medical Bans

61. On June 2, 2022, Defendant Ladapo sent a letter to the Florida Board

of Medicine and the Florida Board of Osteopathic Medicine (collectively, the “Boards”) asking the Boards to “establish a standard of care” for the treatment of gender dysphoria, notwithstanding the widely accepted standards of care and clinical practice guidelines established by WPATH and the Endocrine Society.

62. On July 28, 2022, the Florida Department of Health sent the Boards a “Petition to Initiate Rulemaking,” asking the Board, among other things, to adopt a categorical ban on all treatment of gender dysphoria for people under eighteen years of age.

63. On August 5, 2022, the Boards discussed the June 2, 2022 letter from Dr. Lapado and the July 28, 2022 Petition to Initiate Rulemaking. The Boards voted to accept the Petition to Initiate Rulemaking.

64. On September 1, 2022, the Boards each published a Notice of Development of Rulemaking in the Florida Administrative Register (F.A.R.), proposing “rule development to clarify the practice standards for treatment of gender dysphoria in minors.”

65. On October 14, 2022, the Boards each published a Notice of Rule Workshop, which would take place on October 28, 2022.

66. On October 28, 2022, the Boards held a Joint Workshop regarding the development of a rule related to “Practice Standards for the Treatment of Gender Dysphoria.” At the conclusion of the meeting, the Boards voted in support of

proposed rules that would ban puberty blockers and hormones, with an exception for treatment performed as clinical trials under the auspices of the Institutional Review Board. The proposed rules were as follows:

- (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) Nonsurgical treatments for the treatment of gender dysphoria in minors may continue to be performed under the auspices of Institutional Review Board (IRB) approved, investigator-initiated clinical trials conducted at any of the Florida medical schools set forth in Section 458.3145(1)(i), Florida Statutes. Such clinical trials must include long term longitudinal assessments of the patients' physiologic and psychologic outcomes.
- (3) Minors being treated with puberty blocking, hormone, or hormone antagonist therapies prior to the effective date of this rule may continue with such therapies.

67. On November 4, 2022, the Florida Board of Medicine voted to remove the exception from its proposed transgender medical ban.

68. On January 9, 2023, the Boards published Notices of Public Hearing in the Florida Administrative Register, regarding a joint hearing of the Boards scheduled to take place on February 10, 2023.

69. On February 10, 2023, during the Public Hearing, the Florida Board of Osteopathic Medicine voted to remove the exception from its proposed transgender medical bans.

70. The Florida Board of Medicine filed the following rule with the Florida

Department of State on February 24, 2023, with an effective date of March 16, 2023:

- (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.

71. The Florida Board of Osteopathic Medicine filed the following rule with the Florida Department of State on March 8, 2023, with an effective date of March 28, 2023:

- (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.

72. The transgender medical bans include a clause that permits minors being treated with puberty blockers or hormones prior to the effective date of the transgender medical bans to continue to receive those treatments.

73. Transgender minors who were not yet receiving puberty blockers or hormones when the transgender medical bans took effect are barred from obtaining

such treatment from a Florida doctor regardless of medical necessity.

74. The transgender medical bans ignore the established medical and scientific consensus that these treatments are medically necessary, safe, and effective for the treatment of gender dysphoria.

75. The transgender medical bans are in direct conflict with state laws ensuring that parents have the right to make medical decisions for their adolescent children. *See* Florida Statutes 1014.02 (which provides that “it is a fundamental right of parents to direct the upbringing, education, and care of their minor children.”); Florida Statutes 1014.03 (“The state, any of its political subdivisions, any other governmental entity, or any other institution *may not infringe on the fundamental rights of a parent to direct* the upbringing, education, *health care*, and mental health of his or her minor child[.]”) (emphasis added).

III. The Transgender Medical Bans Will Irreparably Harm the Plaintiffs

Jane Doe and her daughter Susan Doe

76. Susan Doe is an eleven-year-old transgender girl who resides with her mother, Jane Doe, her father, and her three siblings in St. Johns County, Florida.

77. From an early age, Susan began telling her parents that she is a girl. She began living fully as a girl, with the support of her family and upon advice of her pediatrician by the time she started kindergarten.

78. Susan has been diagnosed with gender dysphoria and that diagnosis has

been confirmed by many doctors, including her doctor at the Pentagon. Susan has not been prescribed puberty blockers or hormones to treat her gender dysphoria.

79. Susan's medical providers, including her pediatrician, pediatric endocrinologist, and medical provider on base, continue to monitor her treatment and concluded that it likely will be medically necessary for her to begin puberty blocking medications after she begins puberty, which is imminent. The transgender medical bans, however, will prevent her from obtaining treatment.

Brenda Boe and her son Bennett Boe

80. Bennett Boe is a fourteen-year-old transgender boy who resides in Alachua County, Florida, with his mother, Brenda Boe.

81. Bennett has known that he was not a girl since the third grade. After he began puberty and started experiencing the accompanying physical changes, Bennett grew increasingly distressed by the mismatch between his body and his sense of himself as a boy. Around that time, Bennett experienced debilitating depression, culminating in an incident of self-harm resulting in hospitalization.

82. Bennett's mother Brenda took Bennett to see medical professionals who diagnosed Bennett with gender dysphoria and recommended treatment, including menstrual suppression medication. With Brenda's consent, Bennett began treatment which has considerably alleviated his depression.

83. Even with that treatment, Bennett continues to experience gender

dysphoria as a result of continued pubertal development inconsistent with his sense of himself as a boy.

84. Bennett's doctors believe it may be medically necessary for him to begin hormone therapy after he turns sixteen.

85. Brenda and Bennett fear that the transgender medical medical bans will prevent him from being able to treat his ongoing symptoms of gender dysphoria with hormone therapy.

Carla Coe and her daughter Christina Coe

86. Christina Coe is a nine-year-old transgender girl, and one of three triplets, who resides in Duval County, Florida with her mother, Carla Coe, her father, and her siblings.

87. From an early age, Christina began to say to her parents that she is a girl.

88. At age five Christina began to express distress including suicidal ideation and a desire to harm herself.

89. Since entering the third grade, Christina has been living as a girl in all aspects of her life. She has not expressed a renewed desire to harm herself.

90. Carla and her husband fear that Christina will not be able to get the medical care she needs after she begins puberty because of the transgender medical bans.

Fiona Foe and her daughter Freya Foe

91. Freya Foe is a ten-year-old transgender girl who resides with her mother, Fiona Foe, her father, her grandmother, and her two siblings in Orange County, Florida.

92. As soon as she could walk and talk, Freya was very feminine in her self expression, including her choices of clothing and toys.

93. As she grew older, Freya began to express distress about being seen as a boy. Fiona and her husband took Freya to see a psychologist who diagnosed her with gender dysphoria.

94. Shortly before her tenth birthday, Freya's doctor examined her and determined that she had reached Tanner Stage 2, meaning puberty is in progress. In the months preceding this examination, Freya had begun to express distress about the onset of puberty and her performance in school began to decline.

95. In December 2022, Freya's doctors determined that puberty blocking medication was medically necessary for the treatment of her gender dysphoria. With the consent of her parents, Freya began puberty blocking medication. Since then, Freya's overall wellbeing and performance in school have improved.

96. The transgender medical bans will prevent Freya's medical providers from prescribing hormones to allow her to go through female puberty, medication she may need as her peers continue to develop through puberty.

Gloria Goe and her son Gavin Goe

97. Gavin Goe is an eight-year-old transgender boy who resides with his mother, Gloria Goe, his father, and his siblings in Lee County, Florida.

98. Gavin identified as a boy a very young age, pointing to photographs of boys to let others around him know how he felt. Eventually, he asked his parents why he could not have a boy's name and why people did not believe he was a boy.

99. Gradually over time, Gavin's parents supported him in taking steps to live more fully as a boy.

100. By the time Gavin entered first grade, he was living as a boy in all aspects of his life.

101. Gavin was assessed for gender dysphoria by his pediatrician in 2022, who referred Gavin to a pediatric endocrinologist for further assessment and treatment because of Gavin's age, development, and family history.

102. Gloria made an appointment for Gavin with the pediatric endocrinologist at a clinic for March of 2023. She learned, just before the appointment, that it was cancelled because the clinic is no longer seeing new patients due to the transgender medical bans.

103. Gloria and Gavin know that irreversible changes can happen in Gavin's body at any time due to the onset of puberty and that he needs to be assessed regularly by a pediatric endocrinologist to determine if and when he needs puberty

blockers to effectively treat his gender dysphoria.

Linda Loe and her daughter Lisa Loe

104. Lisa Loe is an eleven-year-old transgender girl who resides with her mother, Linda Loe, her father, and her sibling in Miami-Dade County, Florida.

105. As a child, Lisa identified closely with her female friends and strongly preferred toys and activities more commonly associated with girls.

106. At age nine, Lisa said that she knew she was a girl.

107. Lisa's parents took her to see a psychologist who assisted them in supporting Lisa to live consistently with her gender identity.

108. Lisa was evaluated in Fall of 2022 by a pediatric endocrinologist who confirmed her diagnosis of gender dysphoria and recommended that she return for another appointment in six months because she was likely to start puberty soon.

109. Lisa was evaluated again in March of 2023 and her doctor confirmed that she has reached puberty and advised that it would be necessary to begin puberty blockers within approximately three months. The doctor also advised that the transgender medical bans made it impossible for the doctor to prescribe puberty blockers to Lisa.

110. Irreversible changes are occurring in Lisa's body at this time, which are causing her significant distress. Lisa and her family cannot meet her urgent medical needs because of the barriers they are facing in Florida finding the medical care she

needs.

Patricia Poe and her son Paul Poe

111. Paul Poe is a nine-year-old transgender boy who resides with his mother, Patricia Poe, and his sister in Miami-Dade County, Florida.

112. From a young age, Paul began asking consistently to use the boys' bathroom and to be referred to as a boy and a brother.

113. Paul began wearing boys' clothing, using a boy's name when away from home, and, with the advice and support of a therapist, living as a boy at school and in all other aspects of his life.

114. In late 2022, Paul's body began changing with the onset of puberty. Patricia took him to see a pediatric endocrinologist who determined that Paul was far enough along in puberty that he may need puberty blockers. The pediatric endocrinologist recommended that Paul see a psychologist to confirm his medical need for puberty blockers.

115. In February 2023, a psychologist evaluated Paul and determined that he needs to begin treatment with puberty blockers to alleviate his gender dysphoria. Paul began treatment at that time.

116. Shortly thereafter, Paul's pediatric endocrinologist told Patricia that the endocrinologist was unable to continue prescribing or monitoring the treatment in light of the transgender medical bans. Paul's family must find medical providers

outside of Florida to secure the care he needs which presents a hardship to the family and potential harms because of disruption to the continuity of his care, as long as the transgender medical bans are in effect.

CLAIMS FOR RELIEF

COUNT I

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

117. The plaintiffs incorporate all paragraphs 1-116 of the Amended Complaint as if set forth fully herein.

118. The parent plaintiffs bring this Count against all the defendants.

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

120. The transgender medical bans violate this fundamental right by preventing the parent plaintiffs from obtaining medically necessary care for their minor adolescent children.

121. By intruding upon parents’ fundamental right to direct the upbringing of their adolescent children, the transgender medical bans are subject to strict scrutiny.

122. The defendants have no compelling justification for preventing parents from ensuring their adolescent children can receive essential medical care. The transgender medical bans do not advance any legitimate interest, much less a compelling one.

COUNT II
Deprivation of Equal Protection
All Plaintiffs Against Defendants in Their Official Capacities
U.S. Const. Amend. XIV

123. The plaintiffs incorporate Paragraphs 1–116 of the Amended Complaint as if set forth fully herein.

124. All the plaintiffs bring this Count against all the defendants.

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

126. The transgender medical bans single out transgender minors and prohibit them from obtaining medically necessary treatment based on their sex and transgender status.

127. Under the Equal Protection Clause, government classifications based

on sex are subject to heightened scrutiny and are presumptively unconstitutional.

128. Transgender-based government classifications are subject to heightened scrutiny because they are sex-based classifications.

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

130. As such, transgender classifications are subject at least to intermediate scrutiny.

131. The transgender medical bans do nothing to protect the health or well-being of minors. To the contrary, the transgender medical bans undermine the health and well-being of transgender minors by denying them essential medical care.

132. The transgender medical bans are not narrowly tailored to further a compelling government interest, substantially related to any important governmental interest, or even rationally related to a governmental interest. Accordingly, the transgender medical bans violate the Equal Protection Clause of the Fourteenth Amendment.

RELIEF REQUESTED

WHEREFORE, the plaintiffs request that this Court:

- (1) issue a judgment, pursuant to 28 U.S.C. §§ 2201-2202, declaring that the transgender medical bans violate the United States Constitution for the reasons and on the Counts set forth above;
- (2) temporarily, preliminarily, and permanently enjoin the defendants and their officers, employees, servants, agents, appointees, or successors from enforcing the transgender medical bans;
- (3) declare that the transgender medical bans violate the Fourteenth Amendment to the United States Constitution;
- (4) award the plaintiffs their costs and attorneys' fees pursuant to 42 U.S.C. § 1988 and other applicable laws; and
- (5) grant such other relief as the Court finds just and proper.

Respectfully submitted this 24th day of April, 2023.

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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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Doc. 30

Doe v Ladapo: 4:23-cv-114

**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.

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 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 serious 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
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**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.

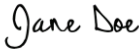
28. After the final rule was filed with the Department of State, removing all doubt that Florida doctors would soon be prohibited from providing evidence-based medical treatment for children in Florida like Susan, we flew Susan to Washington D.C. to meet with the chief pediatric endocrinologist at the 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:

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.

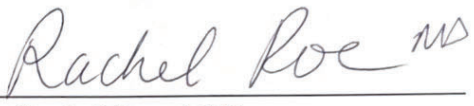
9. In my professional opinion, the patient is at serious risk of irreparable harm if she cannot be prescribed puberty blockers by her treating physicians upon the onset of puberty, which could be any day now. My understanding is that the new rules adopted by the Florida Board of Medicine and the Florida 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,



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.

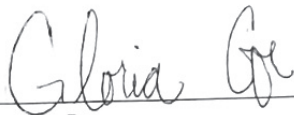
22. My husband and I are concerned that our son will begin puberty and will be unable to get the treatment he needs for his gender dysphoria to prevent the development of secondary sex characteristics associated with his birth sex.

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

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.

Marro Centre West
13650 Metropolis Ave, Suite 101
Fort Myers, FL 33912

Estero Professional Center
9911 Cockscrow Road, Suite 101
Estero, FL 33928

Cape Coral Clinical Office
632 Del Prado Blvd. N, Suite 301
Cape Coral, FL 33909

**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 ADOLESCENTS

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, Vettters 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, Kushner ES, Mandel F, Caretto A, Lewis HC, Anthony LG: Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents, *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 Summit, 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

BIBLIOGRAPHY

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Campbell, Travis and Rodgers, Yana van der Meulen, Conversion Therapy, Suicidality, and Running Away: An Analysis of Transgender Youth in the U.S. (November 15, 2022). Available at SSRN: <http://dx.doi.org/10.2139/ssrn.4180724>

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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

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: September 13, 2023

/s/ Mohammad O. Jazil

No. 23-12159

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

Jane Doe et al.,
Plaintiffs-Appellees,

v.

Surgeon General, State of Florida et al.,
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:23-cv-114
(Hinkle, J.)

APPELLANTS' APPENDIX – VOLUME II OF XIII

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Dated: September 13, 2023

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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.

A handwritten signature in black ink, appearing to read 'A. Janssen', is positioned above a horizontal line.

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, <i>Transgender Health</i>
2014-present	Ad Hoc Reviewer, <i>LGBT Health</i> .
2016-present	Ad Hoc Reviewer, <i>JAACAP</i>
2018-present	Associate Editor, <i>Transgender Health</i>
2020-present	Ad Hoc Reviewer, <i>Pediatrics</i>

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.R.L. “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 Symposium
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

<u>Study Title</u>	<u>IRB Study#</u>	<u>Dates</u>
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
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**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, Maisonnobe 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.

A handwritten signature in black ink, appearing to read "Brittany Bruggeman", is written over a horizontal line.

BRITTANY BRUGGEMAN, M.D.

Exhibit A

Brittany S. Bruggeman

Curriculum Vitae Assistant Professor of Pediatric Endocrinology *E-mail:* bruggemanbr@gmail.com
UF Health Shands Children's Hospital *Phone:* 321-537-8832
University of Florida
Gainesville, FL 32608

Education **University of Florida**, Gainesville, FL

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-mydratic 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

WGPU 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

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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.
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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.
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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>
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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.
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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.
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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-mydratic 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-mydratic 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-mydratic 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

BIBLIOGRAPHY

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Doc. 55

Doe v Ladapo: 4:23-cv-114

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.

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

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

Defendants.

**THE STATE'S RESPONSE IN OPPOSITION TO PLAINTIFFS'
PRELIMINARY-INJUNCTION MOTION**

Defendants Surgeon General Ladapo, the Florida Board of Medicine, and the Florida Board of Osteopathic Medicine (collectively, the "State") oppose Plaintiffs' preliminary-injunction motion. The reasons for denying the motion are detailed in the accompanying memorandum.

Dated: May 15, 2023

/s/ Mohammad O. Jazil
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Counsel for Defendants

CERTIFICATE OF SERVICE

I certify that, on May 15, 2023, this response was filed through the Court's CM/ECF system, which will send a notice of electronic filing to all counsel of record.

/s/ Mohammad O. Jazil
Mohammad O. Jazil (FBN 72556)

INTRODUCTION

Simply put, Plaintiffs aren't entitled to a preliminary injunction. The fact remains that puberty blockers, cross-sex hormones, and surgeries to treat gender dysphoria in minors remain experimental and come with potentially negative and permanent health consequences. Plaintiffs' evidence doesn't change this conclusion, and Plaintiffs fail to establish the four preliminary-injunction factors. Their motion should be denied.

BACKGROUND

In *Dekker v. Weida*, 4:22-cv-325 (N.D. Fla. 2022) ("*Dekker* Doc."), the Florida Agency for Health Care Administration provided its position on gender dysphoria, treatments for gender dysphoria, the federal government's inconsistency on these treatments, and the unreliability of the World Professional Association for Transgender Health's standards of care and Endocrine Society's clinical guidelines. *See Dekker* Doc.120 (AHCA's summary-judgment motion); *Dekker* Doc.49 (AHCA's response in opposition to preliminary-injunction motion). The State incorporates and adopts by reference the arguments made and the evidence provided by AHCA in *Dekker*. But for the purposes of this response, the State briefly notes the following.

I. Gender Dysphoria and the State's Choices

Gender dysphoria is the distressing incongruence between an individual's *biological sex* and *gender identity*. *Dekker* Doc.120-12 ¶ 28 (Levine report); *Dekker* Doc.120-13 ¶ 54 (Hruz report). Biological sex is "determined at conception" at the chromosomal level, and it "structures [an] individual's biological reproductive capabilities." *Dekker*

Doc.120-12 ¶¶ 20-21; *see also Dekker* Doc.120-13 ¶¶ 13-18. While sex is biologically based, gender “is a human phenomenon.” *Dekker* Doc.120-12 ¶ 22.

Gender refers to the traits society associates with biological males and biological females. *Id.* ¶¶ 19-27; *Dekker* Doc.120-13 ¶ 19. Gender identity is an individual’s subjective sense of his or her gender. *Dekker* Doc.120-12 ¶¶ 24-27; *Dekker* Doc.120-13 ¶ 20. Unlike sex, gender identity is mutable. *See Dekker* Doc.120-13 ¶ 58; *Dekker* Doc.120-14 at 43 (WPATH standards of care) (“[P]eople may spend some time in a gender identity or presentation before they discover it does not feel comfortable and later adapt it or shift to an earlier identity or representation.”).

Gender dysphoria is a psychiatric diagnosis. *Dekker* Doc.120-12 ¶ 36. There are no laboratory tests, imaging, or biopsies that can help establish a diagnosis. *Dekker* Doc.120-13 ¶¶ 57-58; *see also Dekker* Doc.120-15 ¶ 24 (Laidlaw redacted report).

For those with gender dysphoria, however, behavioral health services can help. *See, e.g., Dekker* Doc.120-12 ¶¶ 42-49; *Dekker* Doc.120-16 ¶ 136 (Kaliebe report). Florida doesn’t prohibit these services. But, unlike behavioral health services, surgeries, puberty blockers, and cross-sex hormones come with risks, and their efficacy is suspect—especially for minors.

In *Dekker*, Drs. Hruz, Laidlaw, and Van Meter all discussed the concerns associated with puberty blockers and cross-sex hormones. *Dekker* Doc.120-13 ¶¶ 67-87; *Dekker* Doc.120-15 ¶¶ 66-140, ¶¶ 149-58; *Dekker* Doc.120-17 ¶ 20 (Van Meter rebuttal report). Dr. Hruz explained that puberty blockers suppress natural puberty.

Dekker Doc.120-13 ¶¶ 67-68. But he cautioned that after “an extended period of pubertal suppression,” you can’t “turn back the clock” and “reverse changes in the normal coordinated pattern of adolescent psychological development and puberty.” *Id.* ¶ 75. Evidence to the contrary is “very weak.” *Id.* ¶ 78. Puberty blockers and cross-sex hormones also come with a laundry list of potential health consequences, including issues with bone density, fertility, cancer, and brain maturation. *Id.* ¶¶ 67-87.

Dr. Scott provided a neuroscientist’s perspective on puberty blockers, which are the first step on the road to physical transition. She explained that the current science doesn’t support puberty-blocking treatments for minors with gender dysphoria and that such science is needed, given the “considerable changes” that are happening to brain development during and after puberty. *Dekker* Doc.120-18 ¶¶ 12-13 (Scott report). She stated that “more research” is needed to justify this treatment. *Id.* ¶ 16. Current studies suggest that puberty blockers could lead to negative (and perhaps “irreversible”) effects: lower IQ scores, lower heart rates, greater emotional reactivity, higher anxiety, greater avoidance behavior, and more risk-taking behavior. *Id.* ¶ 15.

Dr. Lappert, a plastic surgeon, worried that surgical treatments to cut healthy tissue are firmly in the realm of cosmetic surgeries. *Dekker* Doc.120-19 ¶¶ 47-50 (Lappert report). These treatments introduce the prospect of complications and pose ethical concerns because, unlike other cosmetic procedures, the goal is to induce “functional loss” of the breasts and genitalia. *Id.* ¶¶ 47-50.

There are also mental-health consequences to hormone therapies and surgeries. Dr. Levine, a psychiatrist, commented that “[g]ender transition routinely leads to isolation from at least a significant portion of one’s family in adulthood” and can impact future romantic relationships. *Dekker* Doc.120-12 ¶¶ 198-99. That can negatively affect mental health. Dr. Levine also responded to claims of *positive* mental health outcomes and *lower* suicidality after hormone therapies: many of those claims lack quality evidence. *Id.* ¶¶ 134-73. And Dr. Levine noted that those with gender dysphoria likely have mental health comorbidities—anxiety disorders, ADHD, autism spectrum disorder, OCD, for example. *Id.* ¶¶ 43, 134. As such, it remains unclear whether hormone therapies and surgeries will resolve underlying mental-health concerns.

II. Florida Joins the International Consensus

Countries that were at the forefront of gender-dysphoria treatments have now backtracked their positions. Finland’s National Science Review, for example, concluded that “[i]n light of available evidence, gender reassignment of minors is an experimental practice.” *Dekker* Doc.13 ¶ 124. Finland reached this conclusion after noting that “there are no medical treatments (for transitioning) that can be considered evidence-based” and that the “reliability of the existing studies with no control groups is highly uncertain,” especially considering the potential “risks” of such treatments, such as bone-growth and neurological issues. *Id.*

Sweden reached a similar conclusion. Its board of health said that “the risks of puberty blockers and gender-affirming treatment are likely to outweigh the expected

benefits of these treatment[s]” in minors, and that such treatments should be provided only in rare cases and ideally as part of experimental trials. *Id.* ¶ 125.

The United Kingdom went further still. Its National Institute of Health and Care Excellence reviewed studies that support hormone therapy for gender-dysphoric minors. *Id.* ¶ 126. The institute concluded that “all small, uncontrolled observational studies” for puberty blockers “are of very low certainty using modified GRADE” and they “reported physical and mental health comorbidities and concomitant treatments very poorly.” *Id.* As for cross-sex hormones, the institute stated that evidence of their effectiveness was also of a “very low” quality. *Id.* The United Kingdom’s Cass Report, which reviewed gender-identity services in the country, stated that there’s a “lack of consensus and open discussion about the nature of gender dysphoria and therefore about the appropriate clinical response.” *Id.*

Other countries agree. France’s Académie Nationale de Médecine says that “great medical caution” must be taken “given the vulnerability, particularly psychological, of this population [gender-dysphoric minors] and the many undesirable effects, and even serious complications, that some of the available therapies can cause.” *Dekker* Doc.53 at 11. The Royal Australian and New Zealand College of Psychiatrists has said that there’s a “paucity of quality evidence on the outcomes of those presenting with gender dysphoria.” *Id.* And Norway has also found the support for the excluded treatments to be “insufficient,” and their “long-term effects” to be “little known.” *Dekker* Doc.120-1.

III. The State's Medical Boards Pass Reasonable Rules

In 2022, the Florida Board of Medicine and the Florida Board of Osteopathic Medicine initiated rulemaking processes to create standards of practice for treating gender dysphoria in minors. Throughout the rulemaking process, the boards made sure to hear testimony and evidence from both sides of the medical debate. For example, during an August 2022 meeting, the Board of Medicine invited and heard from Dr. Michael Haller, a University of Florida pediatric endocrinologist and proponent of gender-transition treatments.¹ Two months later, at a joint meeting, the Board of Medicine and the Board of Osteopathic Medicine invited and heard testimony from Dr. Kristin Dayton, Dr. Meredith McNamara, and Dr. Aron Janssen, who support such treatments as well²; Dr. Janssen, in fact, submitted expert reports for Plaintiffs in this case and the *Dekker* case. Doc.30-5; *Dekker* Doc.120-28.

After conducting several hearings, the boards promulgated rules that contain the same language:

- (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.

¹ The meeting minutes can be assessed here: <https://bit.ly/3BqyUtS>.

² The meeting minutes can be assessed here: <https://bit.ly/3W0LARP>.

Rule 64B8-9.019, Fla. Admin. Code; Rule 64B15-14.014, Fla. Admin. Code.

The Board of Medicine’s rule went into effect on March 16, 2023, and the Board of Osteopathic Medicine’s rule went into effect on March 28, 2023.

LEGAL STANDARD

A preliminary injunction “is an extraordinary and drastic remedy,” a “powerful exercise of judicial authority in advance of trial.” *Ne. Fla. Chapter of Ass’n of Gen. Contractors v. Jacksonville*, 896 F.2d 1283, 1284-85 (11th Cir. 1990) (cleaned up). Accordingly, the moving party bears the heavy burden of establishing four factors: (1) a substantial likelihood of success on the merits, (2) irreparable harm absent a preliminary injunction, (3) that the threatened harm outweighs any harm to the nonmoving party, and (4) that the public interest favors a preliminary injunction. *Id.* The first two factors are the most important, and when the State is the nonmoving party, the last two factors merge. *Swain v. Junior*, 958 F.3d 1081, 1088, 1091 (11th Cir. 2020).

ARGUMENT

Plaintiffs fail to establish all four preliminary-injunction factors. In fact, their motion omits more than it includes. For substantial likelihood of success on the merits, Plaintiffs disregard the operative substantive-due-process-analytical framework, and they completely omit *Dobbs v. Jackson Women’s Health Organization*, 142 S. Ct. 2281 (2022), and *Adams v. School Board of St. Johns County*, 57 F.4th 7911 (11th Cir. 2022) (en banc), in their equal-protection arguments. For irreparable harm, Plaintiffs don’t include any

medical records. And for the remaining factors, Plaintiffs fail to appreciate that the State is harmed when it can't enforce its laws and that the State has a compelling interest in protecting minors against experimental treatments.

I. Plaintiffs Are Unlikely to Succeed on the Merits

Plaintiffs are unlikely to succeed on their substantive-due-process and equal-protection challenges to the two State rules. The *Eknes-Tucker* Eleventh Circuit panel has suggested as much when reviewing similar challenges to Alabama's gender-dysphoria legislation. *See generally* Oral Argument, *Eknes-Tucker v. Gov. of the State of Ala.*, 22-11707 (Nov. 18, 2022). That take makes sense: binding Supreme Court and Eleventh Circuit precedent clearly foreclose both claims.

A. Plaintiffs Don't Have a Fundamental Right to Gender-Dysphoria Treatments

Plaintiffs contend that the State rules "violate the fundamental right of the Parent Plaintiffs to obtain established medical care for their children." Doc.30 at 18. The *Eknes-Tucker* Eleventh Circuit panel suggested that this isn't a strong argument. *See* Oral Argument at 18:00-13, *Eknes-Tucker v. Gov. of the State of Ala.*, 22-11707 (Nov. 18, 2022). Plaintiffs' arguments here aren't made any stronger by the absence of the operative substantive-due-process legal framework in their motion. The State thus provides the operative framework for them.

A. A "substantive-due-process analysis has two primary features." *Washington v. Glucksberg*, 521 U.S. 702, 720-21 (1997). The first feature is a careful and precise

description of the asserted fundamental right. *See Reno v. Flores*, 507 U.S. 292, 302 (1993) (Courts must craft a “careful description of the asserted right”). The asserted right must be “narrowly frame[d]” to “the specific facts” of the case. *Doe v. Moore*, 410 F.3d 1337, 1344 & n.4 (11th Cir. 2005). It shouldn’t be abstracted. *Morrissey v. United States*, 871 F.3d 1260, 1269 (11th Cir. 2017). When a party abstracts a right, courts intervene and properly prescribe the asserted right:

- In *Reno v. Flores*, an immigration case, the asserted right *wasn’t* a right to be free from bodily restraint *or* a right of a “child to be released from all other custody into the custody of its parents, legal guardians, or even close relatives.” Instead, the asserted right was a “right of a child who has no available parent, close relative, or legal guardian, and for whom the government is responsible, to be placed in the custody of a willing-and-able private custodian rather than of a government-operated or government selected child-care institution.” 507 U.S. at 302.
- In *Morrissey v. United States*, the asserted right *wasn’t* the right to procreate. Instead, the asserted right was “whether a man has a fundamental right to procreate via an [in-vitro-fertilization] process that necessarily entails the participation of an unrelated third-party egg donor and a gestational surrogate.” 871 F.3d at 1269.
- In *Doe v. Moore*, the asserted right *wasn’t* a right to family association, a right to be free from threats, a right to be free of interference with religious practices, *or* a right to find or keep employment. Instead, the asserted right was a “right of a person, convicted of ‘sexual offenses,’ to refuse subsequent registration of his or her personal information with Florida law enforcement and prevent publication of this information on Florida’s Sexual Offender/Predator website.” 410 F.3d at 1343-44.
- In *Case v. Ivey*, the asserted right *wasn’t* a right to “direct the upbringing of” “children.” Instead, the asserted right was a right of parents “to dress their children and what kind of medical care to provide them in the specific context of a [COVID] mask mandate.” 2022 WL 2441578, at *8 (11th Cir. July 5, 2022) (*per curiam*).

B. The second feature is that the asserted right must be “deeply rooted in this Nation’s history and tradition.” *Glucksberg*, 521 U.S. at 720-21 (quoting *Moore v. E. Cleveland*, 431 U.S. 494, 502 (plurality op.)). Courts look to whether common law, early state legislatures, and historical court cases recognized the right. *See, e.g., Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2248-56 (2021) (demonstrating that a right to abortion isn’t deeply rooted in the nation’s history and traditions); *Glucksberg*, 521 U.S. at 710 (same for a right to physician-assisted suicide). That way, courts don’t “deduce[]” rights “from abstract concepts,” like “personal autonomy” or privacy. *Glucksberg*, 521 U.S. at 725; *see also id.* at 727 (“That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected.”).

C. Here, Plaintiffs’ asserted fundamental right—a parental right to direct their children’s upbringing—is far too abstract. *See Case*, 2022 WL 2441578, at *8 (stating that the asserted “right to direct the upbringing of” children under *Troxel v. Granville* was too abstract). Instead, the claimed right should be “narrow[ed]” to “the specific facts” of this case. *Moore*, 410 F.3d at 1344. The properly prescribed asserted right is a right for parents to obtain puberty blockers, cross-sex hormones, and surgeries for their minor children to treat the minor children’s gender dysphoria. Of course, Plaintiffs haven’t pleaded or argued that right as such.

Nor have they produced any facts that this right is deeply rooted in our nation's history and tradition. *See, e.g., Dobbs*, 142 S. Ct. at 2248-56 (demonstrating that a right to abortion isn't deeply rooted in the nation's history and traditions); *Glucksberg*, 521 U.S. at 710 (same for a right to physician-assisted suicide). Plaintiffs can't allege such facts because these facts don't exist. There simply isn't a deeply rooted right for parents to obtain gender-transition treatments for their minor children. As a result, such a "novel[]" right can't "be considered 'so rooted in the traditions and conscience of our people as to be ranked as fundamental.'" *Flores*, 507 U.S. at 303 (quoting *United States v. Salerno*, 481 U.S. 739, 751 (1987)).

D. Even if such a right existed, the State would overcome any form of constitutional review: it's "indisputable 'that a State's interest in safeguarding the physical and psychological well-being of a minor is compelling.'" *Otto v. City of Boca Raton*, 981 F.3d 854, 868 (quoting *New York v. Ferber*, 458 U.S. 747, 756-57 (1982)). That interest can only be strengthened when the State is safeguarding minors from experimental treatments with either unknown or potentially negative and permanent health consequences. *See supra*.

E. Before continuing to Plaintiffs' equal-protection challenge, a final word on their asserted substantive-due-process right—a *parental* right to gender-transition treatments for their minor children. It bears noting that a parent's parental-rights claim is "derivative from, and therefore no stronger than," a minor's claim. *Whalen v. Roe*, 429 U.S. 589, 604 (1977). A parent's "right[]" to make decisions for his daughter can be no

greater than his right[] to make medical decisions for himself.” *Doe By & Through Doe v. Pub. Health Tr. of Dade Cnty.*, 696 F.2d 901, 903 (11th Cir. 1983). Because parents don’t have a constitutional right to seek gender-transition treatments—which, again, are experimental—their minor children don’t have such a right, either.

Plaintiffs cite *Bendiburg v. Dempsey*, 909 F.2d 463 (11th Cir. 1990), for the proposition that parents have a right to make child-rearing decisions. Doc.30 at 19. But *Bendiburg* made clear that “[p]arental autonomy may be limited when parental decisions jeopardize the health or safety of a child, and the state can intercede on the child’s behalf.” *Id.* at 470. As established above, the at-issue treatments for gender dysphoria could jeopardize the health and safety of children. Therefore, the State properly promulgated its rules and interceded on Florida children’s behalf.

* * *

All told, Plaintiffs’ substantive-due-process challenge fails.

B. The Equal Protection Clause Doesn’t Apply

Plaintiffs’ equal-protection challenge fares no better. Just as Plaintiffs omit the operative substantive-due-process framework, Plaintiffs omit any discussion of *Dobbs v. Jackson Women’s Health Organization*, 142 S. Ct. 2228 (2022), or even *Adams v. School Board of St. Johns County*, 54 F.4th 791 (11th Cir. 2022) (en banc). These cases defeat their equal-protection claim.

A. State health, safety, and welfare regulations are subject to a “strong presumption of validity.” *Dobbs*, 142 S. Ct. at 2284 (cleaned up). They “must be

sustained if there is a rational basis on which” the State “could have thought that it would serve legitimate state interests.” *Id.*

Here, the two State rules are health, safety, and welfare regulations that make a distinction based on a medical diagnosis: the excluded treatments are generally unavailable to those with gender dysphoria but are available to those with other diagnoses (like breast cancer or precocious puberty). The distinction furthers the State’s interest in protecting its citizens from unnecessary and experimental treatments that lack quality evidence and that threaten to cause permanent harm like sterilization and infertility. Rational-basis review is easily met. *Dobbs*, 142 S. Ct. at 2268; *Otto*, 981 F.3d at 868.

B. Plaintiffs ask for some heightened level of scrutiny to apply because, in their estimation, the State rules make a discriminatory distinction based on sex or transgender status. That isn’t so. The challenged rules classify on the basis of a medical condition, not on the basis of sex or transgender status. The problems with Plaintiffs’ argument are threefold.

First, the en banc Eleventh Circuit in *Adams v. School Board of St. Johns County* forecloses the sex-based discrimination argument. In that case, the court held that a school board’s sex-based bathroom-assignment policy doesn’t violate the Equal Protection Clause. 57 F.4th at 796. The court elaborated that sex-based discrimination is discrimination based on biological sex. *Id.* at 807-08. After all, the Equal Protection Clause protects immutable characteristics, like biological sex. *Id.* (citing *Frontiero v.*

Richardson, 411 U.S. 677, 686 (1973)). That stands in strong contrast to gender identity, which is mutable and isn’t afforded heightened constitutional protection. *Id.* at 807-08.

The *Adams* school-board policy made a distinction on the basis of biological sex: mainly, biologically male students use one bathroom, biologically female students use another bathroom, or a sex-neutral bathroom is available. *Id.* at 802. “This is a sex-based classification,” the Eleventh Circuit held. *Id.* at 801.

That’s different from the two State rules at issue here. The rules don’t make a distinction based on biological sex. The rules make a distinction based on a medical diagnosis—gender dysphoria—which applies to biological males and biological females. *See Lange v. Houston County*, 608 F. Supp. 3d 1340, 1354 (M.D. Ga. 2022); *see also Geduldig v. Aiello*, 417 U.S. 484, 497 n.20 (1974).

Regardless of biological sex, the State prohibits certain gender-dysphoria treatments for minors. Therefore, rational basis—and not heightened scrutiny—applies, and rational basis is still satisfied.

Second, the *Adams* decision forecloses Plaintiffs’ transgender discrimination argument as well. Notably, the court didn’t hold that transgender status is a quasi-suspect class. It said that “we have grave ‘doubt’ that transgender persons constitute a quasi-suspect class” and that “the Supreme Court has rarely deemed a group a quasi-suspect class.” 57 F.4th at 803 n.5 (citing *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 442-46 (1985)). Transgender individuals thus aren’t entitled to heightened constitutional review *per se*. *Id.*

Whether to apply heightened review then turns on a *Geduldig v. Aiello* “identity” analysis. In *Adams*, the Eleventh Circuit asked if there was either an “identity” or “lack of identity” between the school-board bathroom policy and transgender status; an “identity” between the two would potentially demonstrate unconstitutional discrimination, but a “lack of identity” would demonstrate a lack of unconstitutional discrimination. *Id.* at 809 (quoting 417 U.S. at 497).

In conducting the analysis, the *Adams* court observed what groups the bathroom policy created. The court concluded that the policy “divide[d] students into biological male and biological female groups.” *Id.* Because both groups “can inherently contain transgender students,” there was a lack of identity between the policy and transgender status.

The same analysis and conclusion bore out in *Geduldig*. That case concerned a state insurance program that excluded coverage for certain pregnancy-related disabilities. 417 U.S. at 486, 496-97. To determine whether there was an “identity” between the program and sex, the Supreme Court observed what groups the program created. *Id.* at 496 at n.20. According to the Court, the “program divide[d] potential recipients into two groups—pregnant women and nonpregnant persons. While the first group is exclusively female, the second includes members of both sexes. The fiscal and actuarial benefits of the program thus accrue to members of both sexes.” *Id.* As a result, there was a lack of identity between the program and sex, and the Court concluded that the constitution wasn’t violated.

The same analysis applies here. The State rules create two groups—a group affected by the rules, and a group unaffected by the rules. The group affected by the rules include transgender individuals who suffer from gender dysphoria. The group unaffected by the rules includes non-transgender individuals and transgender individuals *who don't* suffer from gender dysphoria. Under *Adams* and *Geduldig*, there's a “lack of identity” between the rules and transgender status. Like the policy in *Adams* and the program in *Geduldig*, the constitution isn't violated.

Third, Plaintiffs can't rely on *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020), and *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011). In *Adams*, the Eleventh Circuit disavowed reliance on *Bostock* on the equal-protection issue, 57 F.4th at 808-09, and the court ostensibly relegated both cases to workplace-discrimination disputes, *id.* at 808-09, 813-14.

* * *

In sum, rational basis applies. That test is easily met. Plaintiffs' equal-protection challenge fails.

II. Plaintiffs Haven't Shown Irreparable Harm

Plaintiffs haven't shown that they would suffer irreparable harm absent a preliminary injunction. As with the previous preliminary-injunction factor, they omit more than they include.

Plaintiffs omit medical records from their preliminary-injunction motion. In *Dekker*, the absence of medical records contributed to the denial of the *Dekker* plaintiffs'

preliminary-injunction motion: the “other reason for denying a preliminary injunction is that the record does not include medical records for these plaintiffs.” *Dekker* P.I. Trans. 113:12-22. Here, instead of medical records, Plaintiffs provided conclusory declarations. To be sure, unlike the *Dekker* case, Plaintiffs provided one declaration from Dr. Rachel Roe (who saw Susan Doe in November 2022) and a letter from Dr. Nicole Bruno (who saw Gavin Doe back in 2022). But these declarations are just as conclusory as the *Dekker* declarations. Like the *Dekker* declarations, the declarations and letter here fail to conclusively demonstrate that gender-transition treatments are necessary for each minor Plaintiff and that such care would do more good than harm. *Compare Dekker* Docs.11-6, 11-7, 11-8, 11-9 (affidavits from *Dekker* plaintiffs), *with Dekker* Doc.49 at 27-30 (Dr. Laidlaw’s evaluation of the *Dekker* plaintiffs’ medical records, explaining that their preferred treatments would do more harm than good). In other words, the declarations and letter fail to establish that Plaintiffs would suffer irreparable harm absent a preliminary injunction.

In sum, Plaintiffs fail to show irreparable harm.

III. Plaintiffs Fail to Establish the Remaining Factors

The remaining preliminary-injunction factors weigh against granting a preliminary injunction. The public benefits from the State guarding against experimental and potentially harmful treatments, especially ones directed at minors. *See Otto*, 981 F.3d at 868 (quoting *Ferber*, 458 U.S. at 756-57); *see also Dobbs*, 142 S. Ct. at 2282 (noting the State’s strong role in making health, safety, and welfare decisions).

The public is also served when the State gets to enforce its laws, and the State is harmed when it's prevented from doing so. *See Hand v. Scott*, 888 F.3d 1206, 1214 (11th Cir. 2018) (The State is “harmed” when it can’t “apply its own laws.”); *see also Maryland v. King*, 567 U.S. 1301, 1301 (2012) (Roberts, C.J., in chambers) (“Any time a State is enjoined by a court from effectuating” its laws, “it suffers a form of irreparable harm.” (cleaned up)).

Because Plaintiffs haven’t established a constitutional violation, haven’t shown irreparable harm, and haven’t shown that their preferred treatments would do more harm than good, these factors tilt decidedly in the State’s favor.

CONCLUSION

For the reasons expressed above, this Court should deny Plaintiffs’ preliminary-injunction motion.

Dated: May 15, 2023

/s/ Mohammad O. Jazil
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LOCAL RULE CERTIFICATIONS

I certify that this memorandum contains 4,312 words, excluding the case style and certifications, and I certify that this memorandum complies with this Court's formatting requirements.

/s/ Mohammad O. Jazil
Mohammad O. Jazil (FBN 72556)

CERTIFICATE OF SERVICE

I certify that, on May 15, 2023, this notice was filed through the Court's CM/ECF system, which will send a notice of electronic filing to all counsel of record.

/s/ Mohammad O. Jazil
Mohammad O. Jazil (FBN 72556)

Doc. 57

Doe v Ladapo: 4:23-cv-114

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

JANE DOE, individually and on behalf
of her minor daughter, SUSAN DOE;
BRENDA BOE, individually and on
behalf of her minor son BENNETT
BOE; CARLA COE, individually and
on behalf of her minor daughter
CHRISTINA COE; FIONA FOE,
individually and on behalf of her minor
daughter FREYA FOE; GLORIA GOE,
individually and on behalf of her minor
son GAVIN GOE; and LINDA LOE,
individually and on behalf of her minor
daughter LISA LOE; PATRICIA POE,
individually and on behalf of her minor
son PAUL POE,

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;
FLORIDA BOARD OF MEDICINE;
SCOT ACKERMAN, NICHOLAS W.
ROMANELLO, Wael Barsoum,
MATTHEW R. BENSON, GREGORY
COFFMAN, AMY DERICK, DAVID
DIAMOND, PATRICK HUNTER,
LUZ MARINA PAGES, ELEONOR
PIMENTEL, HECTOR VILA,
MICHAEL WASYLIK, ZACHARIAH P.
ZACHARIAH, MARIA GARCIA,
NICOLE JUSTICE, *in their official*
capacities as members of the Florida

Board of Medicine; FLORIDA BOARD OF OSTEOPATHIC MEDICINE; WATSON DUCATEL, TIFFANY SIZEMORE DI PIETRO, GREGORY WILLIAMS, MONICA M. MORTENSEN, VALERIE JACKSON, CHRIS CREEGAN, WILLIAM D. KIRSH, *in their official capacities as members of the Florida Board of Osteopathic Medicine*; ASHLEY MOODY, *in her official capacity as Attorney General for the State of Florida*; GINGER BOWEN MADDEN, *in her official capacity as State Attorney for the First Judicial Circuit of Florida*; JACK CAMPBELL, *in his official capacity as State Attorney for the Second Judicial Circuit of Florida*; JOHN DURRETT, *in his official capacity as State Attorney for the Third Judicial Circuit of Florida*; MELISSA NELSON, *in her official capacity as State Attorney for the Fourth Judicial Circuit of Florida*; WILLIAM GLADSON, *in his official capacity as State Attorney for the Fifth Judicial Circuit of Florida*; BRUCE BARTLETT, *in his official capacity as State Attorney for the Sixth Judicial Circuit of Florida*; R.J. LARIZZA, *in his official capacity as State Attorney for the Seventh Judicial Circuit of Florida*; BRIAN S. KRAMER, *in his official capacity as State Attorney for the Eighth Judicial Circuit of Florida*; MONIQUE H. WORRELL, *in her official capacity as State Attorney for the Ninth Judicial Circuit of Florida*; BRIAN HAAS, *in his official*

capacity as State Attorney for the Tenth Judicial Circuit of Florida; KATHERINE FERNANDEZ RUNDLE, in her official capacity as State Attorney for the Eleventh Judicial Circuit of Florida; ED BRODSKY, in his official capacity as State Attorney for the Twelfth Judicial Circuit of Florida; SUSAN S. LOPEZ, in her official capacity as State Attorney for the Thirteenth Judicial Circuit of Florida; LARRY BASFORD, in his official capacity as State Attorney for the Fourteenth Judicial Circuit of Florida; DAVE ARONBERG, in his official capacity as State Attorney for the Fifteenth Judicial Circuit of Florida; DENNIS WARD, in his official capacity as State Attorney for the Sixteenth Judicial Circuit of Florida; HAROLD F. PRYOR, in his official capacity as State Attorney for the Seventeenth Judicial Circuit of Florida; PHIL ARCHER, in his official capacity as State Attorney for the Eighteenth Judicial Circuit of Florida; THOMAS BAKKEDAH, in his official capacity as State Attorney for the Nineteenth Judicial Circuit of Florida; and AMIRA D. FOX, in her official capacity as State Attorney for the Twentieth Judicial Circuit of Florida,

Defendants.

/

**PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING
ORDER OR PRELIMINARY INJUNCTION,**

AND INCORPORATED MEMORANDUM OF LAW

Pursuant to Rule 65 of the Federal Rules of Civil Procedure, Plaintiffs hereby move the Court for a temporary restraining order or a preliminary injunction preventing the enforcement of Florida Senate Bill 254, “An act relating to treatments for sex reassignment” (“SB 254”).¹

1. The Florida Legislature passed SB 254 on May 4, 2023, and the Governor signed SB 254 into law on May 17, 2023.²

2. Among other things, SB 254 creates Florida Statute § 456.52(1), which prohibits medical providers from providing well-established treatment for gender dysphoria to transgender adolescents. SB 254 makes it a third degree felony for any health care practitioner who provides the prohibited medical care.

3. 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. Plaintiffs filed a Motion for Preliminary Injunction (Dkt. No. 30) on April 24, 2023, asking this Court to enjoin enforcement of the Florida Boards of Medicine and Osteopathic Medicine Rules (64B8-9.019, Fla. Admin. Code (effective March 16, 2023) and 64B15-14.014, Fla. Admin. Code (effective March 28, 2023)) (“the Bans”) during the pendency of this litigation.

¹ SB 254, Section 5, creates Florida Statute 456.52, “Sex-reassignment prescriptions and procedures; prohibitions; informed consent.”

² According to the text of SB 254, it will “take effect upon becoming law,” which means it can now be enforced. *See* Fla. SB 254, § 10, line 271 (2023) (Second Engrossed).

4. Plaintiffs incorporate by reference the Statement of Facts contained in Plaintiffs' Motion for Preliminary Injunction and the declarations and other evidence submitted in support thereof. (Dkt. No. 30 at 5–16, Dkt. Nos. 30-1, 30-2, 30-3, 30-4, 30-5, 30-6).

5. For the reasons articulated in Plaintiffs' Motion for Preliminary Injunction (*id.* at 17–28), SB 254 infringes upon Plaintiffs' constitutionally protected rights to make medical decisions for their children (Parent Plaintiffs) and to equal protection under the law in violation of the Fourteenth Amendment of the United States Constitution. Defendants are unable to justify the infringement upon Plaintiffs' constitutional rights that would arise from enforcement of SB 254.

6. Without the requested relief, SB 254 will cause irreparable harm to the Parent Plaintiffs, who will continue to 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 continue to suffer a cascade of mental and physical injuries. Plaintiffs have no adequate remedy at law.

7. The balance of equities and public interest tip sharply in favor of the Plaintiffs because the temporary restraining order or preliminary injunction would preserve the status quo; and the irreparable injuries that Plaintiffs will experience far outweigh any burden on Defendants that might result from enjoining SB 254 during the pendency of this case. In contrast, preventing enforcement of SB 254 while this

litigation proceeds poses no harm to Defendants and will preserve the status quo that has existed for many years before SB 254 was adopted.

8. Plaintiffs respectfully request that the Court exercise its discretion to waive the Federal Rule of Civil Procedure 65(c) security requirement. *BellSouth Telecomm., Inc. v. MCIMetro Access Transmission Servs., LLC*, 425 F.3d 964, 971 (11th Cir. 2005). 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 temporarily restraining or preliminarily enjoining Defendants from enforcing SB 254, creating § 456.52 (2023), Florida Statute.

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 bring this action against Defendant Joseph A. Ladapo, in his official capacity as Florida's Surgeon General, Defendant members of the Florida Board of Medicine and the Florida Board of Osteopathic Medicine (the "Medical Boards") in their official capacities, Defendant Ashley Moody, in her official capacity as Attorney

General of Florida, and Defendant State Attorneys in their official capacities, challenging the constitutionality of SB 254.

Plaintiffs seek an order restraining or enjoining Defendants from enforcing SB 254, which bans established medical care for transgender minors by subjecting health care providers who provide such treatments to professional discipline, civil liability, and felony criminal liability. *See* attached as Exhibit A, Temporary Restraining Order or Proposed Preliminary Injunction. This categorical ban violates the fundamental right of parents to make medical decisions for their minor children and of transgender minors to be free from discrimination based on their sex and transgender status under the Due Process and Equal Protection provisions of the Fourteenth Amendment.

II. Argument

A. Standard for Granting a Temporary Restraining Order or Preliminary Injunction

A temporary restraining order may be imposed “to protect against irreparable injury and preserve the status quo until the district court renders a meaningful decision on the merits.” *Schiavo ex rel. Schindler v. Schiavo*, 357 F. Supp. 2d 1378, 1383 (M.D. Fla. 2005) *aff’d*, 403 F.3d 1223 (11th Cir. 2005); *see also W. Ala. Women’s Ctr. v. Williamson*, 120 F. Supp. 3d 1296, 1320 (M.D. Ala. 2015). A party seeking a temporary restraining order must show that: (1) it is likely to succeed on the merits; (2) it is likely to suffer irreparable harm in the absence of preliminary relief; (3) the balance of equities tips in its favor; and (4) an injunction is in the public interest. *See*

Winter v. Nat. Res. Def. Council, Inc., 555 U.S. 7, 20 (2008); *Wreal, LLC v. Amazon.com*, 840 F.3d 1244, 1247 (11th Cir. 2016).

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).

B. SB 254 Violates the Due Process and Equal Protection Clauses of the Fourteenth Amendment of the U.S. Constitution

1. The Present Litigation

On April 24, 2023, Plaintiffs in the above-captioned matter filed their First Amended Complaint (Dkt. No. 29), challenging the rules (the “Bans”) enacted by the Florida Board of Medicine and the Florida Board of Osteopathic Medicine (the “Medical Boards”) that bar Florida doctors from providing established medical care to

transgender adolescents. The same day, three Parent Plaintiffs and three Minor Plaintiffs filed a Motion for Preliminary Injunction (Dkt. No. 30), asking this Court to enjoin enforcement of the Bans during the pendency of this litigation. Plaintiffs incorporate by reference the Statement of Facts contained in Plaintiffs’ Motion for Preliminary Injunction. (Dkt. No. 30 at 5–16).

2. SB 254

On May 4, 2023, the Florida Legislature voted to pass SB 254. On May 17, 2023, the Governor of Florida, Ron DeSantis, signed SB 254 into law. According to the text of SB 254, the act “shall take effect upon becoming law,” which means it is now enforceable. *See* Fla. SB 254, § 10, line 271 (2023) (Second Engrossed). On May 17, 2023, Plaintiffs sought leave to file their Second Amended Complaint, challenging SB 254 in addition to the Bans promulgated by the Medical Boards.

Like the Bans, SB 254 prohibits health care providers from providing established medical care to transgender adolescents, which it refers to as “sex-reassignment prescriptions or procedures.” *Id.* at § 4, line 107. First, section 4 of the new law defines “sex” as the “classification of a person as either male or female based on the organization of the human body of such person for a specific reproductive role, as indicated by the person’s sex chromosomes, naturally occurring sex hormones, and internal and external genitalia present at birth.” *Id.* at § 4, lines 102–06. Section 4 of the new law then defines the prohibited medical treatment as the “prescription or administration of puberty blockers for the purpose of attempting to stop or delay

normal puberty in order to affirm a person’s perception of his or her sex if that perception is inconsistent with the person’s sex” at birth, *id.* at § 4, lines 109–13, and the “prescription or administration of hormones or hormone antagonists to affirm a person’s perception of his or her sex if that perception is inconsistent with the person’s sex” at birth. *Id.* at § 4, lines 114–16.

Section 5 bans these treatments for transgender adolescents, providing: “Sex-reassignment prescriptions and procedures are prohibited for patients younger than 18 years of age[.]” *Id.* at § 5, lines 151–53. The penalties associated with the ban on the provision of care for transgender adolescents include being charged with a felony (*id.* at § 5, lines 210–13) (“Any health care practitioner who willfully or actively participates in a violation of subsection (1) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084”) and the imposition of “disciplinary action” by the governing Medical Boards (*id.* at § 5, lines 207–09).

The additional provisions contained in SB 254’s Section 5 sweep broadly, creating additional barriers to access to established medical care for transgender individuals. *See id.* at § 5, lines 175-193 (creating restrictions related to informed consent for individuals of all ages in need of treatment for gender dysphoria); *id.* at § 5, lines 194-199 (banning all health care providers, including advanced practice registered nurses and physicians’ assistants, who are otherwise licensed to prescribe the prohibited medications in Florida, and who were not expressly prohibited from providing this treatment under the Medical Boards’ bans.) The penalties associated

with these sweeping restrictions include a misdemeanor of the first degree (*id.* at § 5, lines 214-217), and other disciplinary action (*id.* at § 5, lines 207-209).

Finally, Section 7, creating Florida Statute 766.318, Civil liability for provision of sex-reassignment prescriptions or procedures to minors, which states: “A cause of action exists to recover damages for personal injury or death resulting from the provision of sex-reassignment prescription or procedures, as defined in s. 456.001, to a person younger than 18 years of age which are prohibited by s. 456.52(1). *Id.* at § 7, lines 241-247.”³

Plaintiffs seek to temporarily restrain or preliminarily enjoin those portions of SB 254 that bar healthcare providers from prescribing or administering medications for transgender adolescents and that impose professional discipline, criminal liability, or civil liability for doing so. Plaintiffs do not seek emergency relief at this time with respect to SB 254’s prohibition of surgeries for transgender minors or with respect to other provisions of SB 254 that amend child custody statutes (§§ 1, 2) or prohibit the use of state funds (§ 3).

3. Plaintiffs Will Likely Succeed on the Merits of their Claims Because SB 254 is Unconstitutional

SB 254 facially discriminates against transgender minors because of their gender non-conformity, barring treatments that “affirm a person’s perception of his or

³ Section 7 also includes removes limitations on punitive damages, and allows an action under this section to be commenced within 20 years after the cessation or completion of the sex-reassignment prescription or procedure. *Id.* at § 7, lines 248-252.

her sex if that perception is inconsistent with the person’s sex” at birth. This language is virtually identical to that used in a similar ban enacted by the Alabama Legislature in 2021. *See* Act. No. 2022-289, Senate Bill 184 (2022), the “Alabama Vulnerable Child Compassion and Protection Act;” *see also Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131 (M.D. Ala. 2021) (preliminarily enjoining Alabama’s ban). As the district court in that case correctly noted:

The Act categorically prohibits transgender minors from taking transitioning medications due to their gender nonconformity. In this way, the Act places a special burden on transgender minors because their gender identity does not match their birth sex. The Act therefore amounts to a sex-based classification for purposes of the Equal Protection Clause.

Id. at 1147 (citing *Glenn v. Brumby*, 663 F.3d 1312, 1317 (11th Cir. 2011) (explaining that “discrimination against a transgender individual because of her gender-nonconformity is sex discrimination”). The same analysis applies to SB 254, which similarly targets transgender minors because of their gender-nonconformity.

SB 254 bars established medical treatments for transgender adolescents, depriving them of any effective treatment for their gender dysphoria and preventing their parents from obtaining this necessary medical care for their children.

For the reasons articulated in Plaintiffs’ Motion for Preliminary Injunction (Dkt. No. 30 at 17–28), SB 254 infringes upon Plaintiffs’ constitutionally protected rights to make medical decisions for their children (Parent Plaintiffs) and to equal protection under the law in violation of the Fourteenth Amendment of the United States

Constitution. Defendants are unable to justify the infringement upon Plaintiffs' constitutional rights that would arise from enforcement of SB 254.

C. SB 254 Will Cause Irreparable Harm to Plaintiffs

For the reasons articulated in Plaintiffs' Motion for Preliminary Injunction (Dkt. No. 30 at 28–32), SB 254 contributes to and exacerbates the irreparable harm caused by the Bans. By depriving Parent Plaintiffs of the ability to provide established and time-sensitive medical care to their children, and depriving Minor Plaintiffs of necessary medical care for a serious medical condition, SB 254 causes serious and irreversible physical and psychological harm, which may include anxiety, depression, severe psychological distress, and suicidality.

Additionally, SB 254 makes medical care even more inaccessible for Plaintiffs than the Bans alone because healthcare providers now face severe criminal penalties and civil liability, in addition to the professional discipline already threatened by the Bans.

Absent emergency relief, it is likely that healthcare providers will not only temporarily cease to provide Minor Plaintiffs and other transgender adolescents in Florida with medically necessary care while this litigation proceeds, but that fear of potential criminal liability will cause some or all providers and clinics who currently serve transgender minors to make irrevocable or difficult-to-reverse decisions to stop serving this population or to relocate to practice in a state that does not impose felony

penalties for practicing well-established care, with the result that even if Plaintiffs ultimately prevail, they may be practically unable to obtain relief.

For this reason, as well as to prevent the irreparable harm caused by denial or delay of time-sensitive medical care, Plaintiffs respectfully urge this Court to grant temporary relief to preserve the Court's ability to make "a meaningful decision on the merits," *Schiavo*, 357 F. Supp. 2d at 1383, which "often requires preserving the status quo." *W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1320.

D. The Equities Weigh in Favor of a Temporary Restraining Order or Preliminary Injunction and Granting Such Relief is in the Public Interest

For the reasons articulated in Plaintiffs' Motion for Preliminary Injunction (Dkt. No. 30 at 32–33), the imminent threat of harm to Plaintiffs outweighs any damage to Defendants, who lack any interest in enforcing an unconstitutional law and who will not suffer any injury caused by delaying enforcement of SB 254. A temporary restraining order or preliminary injunction will merely maintain the status quo by allowing doctors to provide established medical care without the threat of criminal penalties, civil liability, or loss of licensure, and preventing enforcement of an unconstitutional law serves the public interest.

II. Conclusion

For the foregoing reasons, Plaintiffs respectfully request that this Court issue a temporary restraining order or, in the alternative, a preliminary injunction, to enjoin enforcement of SB 254.

Respectfully submitted this 17th day of May, 2023.

SOUTHERN LEGAL COUNSEL

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CERTIFICATE OF WORD COUNT

According to Microsoft Word, the word-processing system used to prepare this
Motion and Memorandum, there are 633 total words contained within the Motion,

and there are 2,076 words contained within the Memorandum of Law.

/s/ Simone Chriss

Simone Chriss

**CERTIFICATE OF SATISFATION OF
ATTORNEY CONFERENCE REQUIREMENT**

Pursuant to Local Rule 7.1(B), counsel for the Plaintiffs conferred with counsel for the Defendants on May 4, 2023 and again on May 17, 2023. Counsel for Defendants indicated that Defendants oppose the relief sought.

/s/ Simone Chriss

Simone Chriss

CERTIFICATE OF SERVICE

I hereby certify that, on May 17, 2023, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system. I further certify that I served by process server the foregoing on the following non-CM/ECF participants:

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Counsel for Plaintiffs

**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.,

**[PROPOSED]
TEMPORARY
RESTRAINING
ORDER**

Defendants.

_____ /

**[PROPOSED] TEMPORARY RESTRAINING ORDER OR
PRELIMINARY INJUNCTION**

Plaintiffs Jane Doe and her daughter Susan Doe, Gloria Goe and her son Gavin Goe, and Linda Loe and her daughter Lisa Loe (collectively, "Plaintiffs") have moved this Court for a preliminary injunction and/or temporary restraining order ("TRO") pursuant to Rule 65(b)(1) of the Federal Rules of Civil Procedure, seeking to block enforcement of Senate Bill 254, "An act relating to treatments for sex reassignment . . ." ("SB 254"), an Act that has become law and went into effect on May 17, 2023.

SB 254 makes it a felony of the third degree for any healthcare practitioner to treat any transgender person younger than the age of 18 with “sex-reassignment prescriptions or procedures” “to affirm a person’s perception of his or her sex.” *See* Fla. SB 254, §§ 4, 5 (2023) (Second Engrossed).

The Court, having considered the pleadings, legal authority, and argument presented in support of Plaintiffs’ Motion, as well as all declarations and other evidence submitted in support of Plaintiffs’ prior Motion for a preliminary injunction, has found and concluded for the specific reasons required under Federal Rule of Civil Procedure 65 that Plaintiffs have demonstrated: (1) a likelihood of success on the merits, (2) irreparable harm in the absence of preliminary relief, (3) the equities weighing in favor of the Plaintiffs, and (4) that granting preliminary relief is in the public interest.

Plaintiffs have established a likelihood of success on the merits of their claim that SB 254 violates the Due Process Clause of the Fourteenth Amendment by interfering with the Parent Plaintiffs’ exercise of their fundamental rights to obtain established medical care for their children. Plaintiffs have also established a likelihood of success on the merits of their claim that SB 254 violates Plaintiffs’ right to equal protection under the Fourteenth Amendment of the United States Constitution by criminalizing the provision of established and necessary medical care to transgender minors.

Plaintiffs have demonstrated that, absent a preliminary order preventing SB 254 from taking effect, they will be denied medical care and suffer irreparable constitutional, physical, emotional, psychological, and other harms for which there is no adequate remedy at law. The criminal provisions of SB 254, if permitted to go into effect, will create impenetrable barriers to the Plaintiffs' ability to find any Florida medical provider willing to assess them for, or provide, essential medical care they need. The balance of hardships between the injuries Plaintiffs will suffer and Defendants' interests weigh in favor of granting Plaintiffs' motion to preserve the status quo, and a TRO or preliminary injunction is in the public interest.

Satisfied that the Plaintiffs have met their burden for obtaining preliminary relief, the Court further finds that issuance of a TRO without a hearing and without notice to defendants or providing them an opportunity to respond is warranted. Plaintiffs have made a showing that immediate and irreparable injury will result to the Plaintiffs if SB 254 takes effect prior to a hearing on Plaintiffs' Motion for Preliminary Injunction, ECF 30 (Apr. 24, 2023), which asks the Court to enjoin enforcement of Board of Medicine and Board of Osteopathic Medicine rules prohibiting the same treatments criminalized by SB 254.

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

IT IS THEREFORE ORDERED that Defendants, as well as their agents, employees, servants, attorneys, successors, and any person in active concert or participation with them, are TEMPORARILY RESTRAINED from enforcing, threatening to enforce, or otherwise requiring compliance with Florida Senate Bill 254 pending the Court's decision on Plaintiffs' Motion for Preliminary Injunction.

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

Done this ____ day of _____, 2023.

Doc. 58

Doe v Ladapo: 4:23-cv-114

**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.

_____ /

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

Plaintiffs reply to Defendants' Response in Opposition to Motion for Preliminary Injunction ("Response"), and state as follows:

INTRODUCTION

A preliminary injunction is proper to preserve the status quo and prevent irreparable harm to vulnerable adolescents who urgently need medical care. Absent an injunction, the minor Plaintiffs will suffer long-lasting physical and psychological harm, and the parent Plaintiffs will be forced to watch their children suffer unnecessary and preventable harm due to the denial of time-sensitive,

medically needed care. Defendants have offered no valid reason for this Court to permit these drastic and discriminatory Bans to remain in effect pending the resolution of this case.

Plaintiffs incorporate and adopt by reference the evidence presented by the Plaintiffs in *Dekker v. Weida*, 4:22-cv-325 (N.D. Fla. 2022).

ARGUMENT

A. Plaintiffs are Likely to Succeed on Their Equal Protection Claim

Defendants do not dispute that classifications based on transgender status, and therefore on sex, are subject to heightened scrutiny, as established by *Glenn v. Brumby*, 663 F.3d 1312, 1316 (11th Cir. 2011).

Instead, Defendants contend that the Bans are based on a medical condition, not on transgender status, and thus warrant only rational basis review. Defendants compare this case to *Geduldig v. Aiello*, 417 U.S. 484 (1974) and *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022), in which the Supreme Court held that policies about pregnancy or abortion do not discriminate against women, *per se*, and thus do not trigger heightened scrutiny under the Equal Protection Clause. (Dkt. 55, at 14–18.) Defendants' arguments have no merit.

Unlike restrictions based on pregnancy or abortion, which do not prevent women from being or living as women, the banned treatments for gender dysphoria (puberty blockers and hormone therapy) are an essential aspect of transgender

identity. They are what allow a transgender person to be transgender—that is, to live consistent with their gender identity rather than be forced to live in accordance with their birth sex. By singling out treatments that target the defining feature of what it means to be transgender—that is, living consistent with a person’s gender identity rather than their birth sex—the Bans create a transgender classification on their face.

In *Geduldig*, the Supreme Court held that an exclusion of coverage under California’s disability insurance program for “injury or illness caused by or arising out of pregnancy,” 417 U.S. at 489, did not trigger heightened scrutiny because there was no evidence that the “selection of the risks insured by the program worked to discriminate against any definable group or class in terms of the aggregate risk protection,” *id.* at 496. That is, the exclusion did not discriminate against women as a class because pregnancy is not inherent to the very definition of being a woman. The Supreme Court endorsed the same approach to abortion restrictions in *Dobbs*. 142 S. Ct. at 2245–46; *see also Bray v. Alexandria*, 506 U.S. 263, n.4 (1993) (noting that “the characteristic that formed the basis of the targeting [of the abortion-related law challenged in *Bray*] was not womanhood, but the seeking of abortion”).

Here, the situation is just the opposite. The banned treatments *are* integral to transgender identity and to the conduct—gender transition—that defines the class; they are precisely the treatments a transgender person needs to transition and thus

to live and thrive as a transgender person. By banning the very treatments that allow transgender people to undergo gender transition and live consistent with their gender identity, the Bans facially discriminate against transgender minors as a “definable group or class.” 417 U.S. at 496. Simply put, whereas the Supreme Court has held that being pregnant or seeking an abortion is not integral to a woman’s identity as such, seeking to transition is integral to a transgender person’s identity, as the Supreme Court recognized in *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020), when it held that an employer discriminated based on transgender status by not permitting a transgender woman to transition on the job. If upheld, the Bans will compel transgender minors to forego treatments essential to their identity—*i.e.*, to their ability to live as who they are, consistent with their gender identity.

The fact that some transgender people can transition to live consistently with their gender identity without medications—through social transition alone—does not change that analysis. Bans on marriage by same-sex or interracial couples are no less based on sexual orientation or race because there are some gay people who do not marry or some people who do not marry someone of a different race. Where a restriction, on its face, targets a protected group, there is no need to evaluate whether every person in the group seeks to exercise the right or benefit affected by the law.

That is the situation here. The Bans do not prohibit treatments that happen to

be used by transgender minors; they prohibit treatments *because* they are used by transgender minors and because they enable transgender minors to live consistently with their gender identity. As such, the Bans discriminate based on transgender status, regardless of whether every transgender adolescent requires the banned medications. For those who do or who may in the future require them, they are essential to the person's very identity as transgender.

Defendants' reliance on *Adams ex rel. Kasper v. Sch. Bd. of St. Johns Cnty.*, 57 F.4th 791 (11th Cir. 2022) is also unavailing. In *Adams*, the Eleventh Circuit held that a policy requiring all students to use restrooms based on their "biological sex" did not discriminate against transgender students because the rule applied to all students, not just to transgender students, and did "not depend in any way on how students act or identify." *Id.* at 809. Here, in contrast, the Bans apply expressly and exclusively only to transgender minors. The Bans do not prohibit puberty blockers and hormone therapy for all minors, but only for transgender minors and *because* they are transgender—that is, only for "therapies and procedures performed for the treatment of gender dysphoria in minors." Rule No. 64B8-9.019 (1), Fla. Admin. Code; Rule No. 64B15-14.014 (1), Fla. Admin. Code.

For the reasons explained above and as other courts have recognized, gender dysphoria and transgender identity are two sides of the same coin. Because a transgender person who is forced to live in accordance with their birth sex will

experience gender dysphoria, banning treatments for gender dysphoria discriminates against transgender people.

In sum, the Bans facially discriminate against transgender minors. As such, they are subject to, and cannot survive, heightened scrutiny. Defendants cannot show that their mere disagreement with the overwhelming medical consensus of experts in the treatment of transgender minors with gender dysphoria constitutes an “exceedingly persuasive justification,” as required. *United States v. Virginia*, 518 U.S. 515, 531 (1996). To the contrary, as demonstrated by the expert declarations submitted in support of Plaintiffs’ Motion and the additional attached declaration from Dr. Kenneth Goodman, the Generally Accepted Professional Medical Standards on the Treatment of Gender Dysphoria (“GAPMS Report”) upon which Defendants relied in promulgating the bans has no scientific merit and disregards basic principles of evidence-based medical practice and science. (Declaration of Kenneth W. Goodman, Ph.D (“Goodman Decl.”) ¶ 17-22.) As Dr. Goodman notes: “Much pediatric practice would be utterly undone and out of bounds if the stance revealed in the GAPMS Report were applied to many conditions afflicting children.” (Goodman Decl. ¶ 19.)

B. Parent Plaintiffs are Likely to Succeed on the Their Due Process Claim

Defendants cannot credibly dispute that the right to seek medical care for one’s child is an established aspect of parents’ fundamental interest “in the care,

custody, and control of their children.” *Troxel v. Granville*, 530 U.S. 57, 65 (2000).
See Parham v. J.R., 442 U.S. 584, 602, 604 (1979); *Bendiburg v. Dempsey*, 909 F.2d 463, 470 (11th Cir. 1990).

In the absence of any precedent supporting their claim that Plaintiffs are asserting a “new” right, Defendants rely on a non-precedential unpublished decision in *Case v. Ivey*, 2022 WL 2441578 (11th Cir. July 5, 2022). *See* 11th Cir. R. 36-2. But even if *Case* were binding precedent, it does not support Defendants’ position. *Case* held only that existing case law did not address the scope of parental rights in the context of mask mandates with sufficient clarity to overcome qualified immunity. 2022 WL 2441578, at *4. There is no issue of qualified immunity here. None of the other cases Defendants cite, *see* Opp. at 10-12, involved the established right of parents to make decisions concerning their children’s medical care.

Defendants also improperly speculate, based on the oral argument in *Eknes-Tucker*, that the Eleventh Circuit may in the future decide that state laws barring health care for transgender minors do not infringe upon parent’s fundamental rights. *See* Opp. at 10. Needless to say, such predictions are not precedent. The district court in *Eknes-Tucker* held that parents “have a fundamental right to direct the medical care of their children,” which “includes the more specific right to treat their children with transitioning medications subject to medically accepted standards.” *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). This Court should reach the same conclusion.

Defendants also contend that Parent Plaintiffs’ due process claim is “derivative from” a minor’s right to access medical treatment. *Opp.* at 13–14. But this is not a case about whether patients have a right to seek new or untested treatments. It is about whether the state may completely bar parents from obtaining established treatments for their children that are the recognized standard of care endorsed by every relevant major medical association in the country, including the American Medical Association and the American Academy of Pediatrics.

A parent’s fundamental right to obtain established medical care for a child stands on its own. For example, parents have a fundamental right to determine whether their child attends a public or private school, *Pierce v. Soc’y of Sisters of Holy Names of Jesus & Mary*, 268 U.S. 510, 535 (1925), even though children do not have a fundamental constitutional right to a public education, *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 35 (1973). Similarly, parents’ fundamental right to obtain established care for their children exists irrespective of whether the child has an underlying right to that medical care.¹

¹ *Doe ex rel. Doe v. Public Health Trust*, 696 F.2d 901, 903 (11th Cir. 1983) (per curiam) does not support Defendants’ position that the parental rights at issue here are “derivative.” In *Doe*, the court acknowledged that “parents have the right to decide what medical attention should or should not be provided for their children”

Defendants also fail to show that the Bans are narrowly tailored to advance a compelling interest. Although states have an interest in protecting health, they must do so within constitutional limits and based on credible evidence. *See, e.g., Roman Catholic Diocese of Brooklyn v. Cuomo*, 141 S. Ct. 63, 68 (2020) (per curiam) (enjoining public health order where the government “has not shown that public health would be imperiled” and the measure infringed upon religious liberty); *Wollschlaeger v. Governor*, 848 F.3d 1293, 1316 (11th Cir. 2017) (holding that the mere assertion of “the need to regulate the medical profession in order to protect the public” was not sufficient to justify an otherwise unconstitutional law).

Defendants acknowledge that transgender children exist. (Dkt. No. 55 at 18.) They acknowledge that gender dysphoria is a serious medical condition that can cause severe suffering and harm. *Id.* at 3. The Bans nevertheless prohibit transgender adolescents in Florida from initiating transition-related care, regardless of their individual circumstances and medical needs. Such an approach—which prohibits an individualized approach to care and the best interests of the adolescents—belies any assertion that the Bans are narrowly tailored to achieve the goal of protecting minors’ health.

but held that the parents’ rights were not violated because they decided voluntarily to admit their daughter to a public hospital and were free to withdraw their consent. *Id.* Here, by contrast, the Bans categorically bars parents from exercising their right to obtain medical care for their children’s gender dysphoria.

C. Other Factors Weigh in Favor of a Preliminary Injunction

Plaintiffs have proffered uncontroverted evidence that if the Minor Plaintiffs do not begin time-sensitive medical treatments soon, they may lose any benefit that treatment would confer, which would constitute irreparable injury.

Defendants claim that Plaintiffs must produce medical records to demonstrate irreparable harm yet have not and cannot identify any case law that states such a requirement. Plaintiffs have submitted sworn testimony that is corroborated by statements from their physicians, and other evidence, which is sufficient evidence to show irreparable injury. (Dkt. No. 30-1, Declaration of Jane Doe; Dkt. No. 30-2, Declaration of Linda Loe; Dkt. No. 30-3, Declaration of Gloria Goe; Dkt. No. 30-4, Declaration of Daniel Shumer, M.D.; Dkt. No. 30-5, Declaration of Aron Janssen, M.D.; Dkt. No. 30-6, Declaration of Brittany Bruggeman, M.D.) For each of these plaintiffs, the inability to initiate puberty blockers creates irreparable harm including:

Psychological distress: Without blockers, each is experiencing heightened gender dysphoria and distress because of the incongruence between their gender identity and the physical changes being caused by puberty, which can lead to other severe mental health issues, including anxiety, depression, suicidality, and self-harm. See Doe Declaration ¶ 15, 22, 26, 29 Exh. A ¶ 10; Goe Declaration ¶ 18; Loe Declaration ¶ 12; Shumer Declaration ¶¶ 59–60; Janssen Declaration ¶¶ 46–48;

Bruggerman Declaration ¶¶ 26–27, 65.

Negative body image: Puberty predictably causes increased distress caused by bodily changes that conflict with a minor’s gender identity. This dissonance can cause long-lasting and irreparable effects on body image, self-esteem, and well-being. *See* Doe Declaration ¶ 15, 18, 22, 29; Loe Declaration ¶ 15; Shumer Declaration ¶ 59; Bruggerman Declaration ¶¶ 26–27.

Social difficulties: Adolescence is a crucial period for social development. Susan and Lisa have lived as girls for years, and Gavin has lived as a boy for years. Knowing that their bodies are developing in ways inconsistent with who they are and who their friends know them to be makes it extremely difficult to fit into their peer groups, which also can have long-lasting negative impacts on their social and personal development. *See* Doe Declaration ¶ 21; Goe Declaration ¶¶ 14, 18; Loe Declaration ¶ 15; Shumer Declaration ¶ 59; Bruggerman Declaration ¶¶ 26–27.

Physical harm. There is a limited window of time to get the benefit of puberty blocking medications. Once pubertal changes such as breast development, musculature, and facial hair begin, they can only be reversed with more invasive medical interventions. Delay in receiving this time-sensitive care will needlessly cause the minor plaintiffs to suffer preventable irreparable physical harms. *See* Doe Declaration, ¶ 29, Exh. A ¶ 8, 10; Goe Declaration, Exh. A; Shumer Declaration ¶ 62; Bruggerman Declaration ¶¶ 26–27, 53.

The balance of equities weighs strongly in favor of issuing a preliminary injunction. A preliminary injunction preserves the status quo by allowing transgender adolescents and their families to pursue essential medical care, which was not prohibited prior to March of this year. The irreversible harm to transgender adolescents who imminently may be forced to undergo endogenous puberty clearly outweighs any potential state interest in immediate enforcement of the Bans.

CONCLUSION

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

Respectfully submitted this 18th day of May, 2023.

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CERTIFICATE OF WORD COUNT

Pursuant to Local Rule 7.1(F), the undersigned counsel certifies that, according to Microsoft Word, the word-processing system used to prepare this Reply Memorandum, there are 2,600 total words contained within this Motion and Memorandum of Law.

/s/ Jason E. Starr
Jason E. Starr

CERTIFICATE OF SERVICE

I hereby certify that, on May 18, 2023, I electronically filed the foregoing
with the Clerk of the Court by using the CM/ECF system.

/s/ Jason E. Starr
Jason E. Starr

**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 KENNETH W. GOODMAN, PhD, FACMI,
FACE.**

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

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

2. The Florida Board of Medicine and Osteopathic Medicine Rules
(64B8-9.019, Fla. Admin. Code (effective March 16, 2023) and 64B15-14.014,
Fla. Admin. Code (effective March 28, 2023)) and Senate Bill 254 ("SB 254"
effective May 17, 2023) (collectively the "Bans") prohibit doctors in Florida from

providing transition medications to minors. I understand a violation of the Board rules is a basis for disciplinary action by the medical boards, and a violation of SB 254 may subject a medical provider to criminal and civil liability.

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

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

BACKGROUND AND QUALIFICATIONS

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

6. I am a full Professor of Medicine with tenure at the University of Miami, with additional appointments in the Department of Philosophy, the Department of Public Health Sciences, and the School of Nursing and Health Studies. My responsibilities include teaching ethics to medical students and trainees and providing continuing education in medical ethics to health professionals at the University of Miami and elsewhere.

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

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

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

10. In preparing this declaration, I reviewed the Florida Medicaid: Generally Accepted Professional Medical Standards on the Treatment of Gender Dysphoria (“GAPMS Report”),¹ the Endocrine Society Clinical Practice Guidelines,² and the World Professional Association for Transgender Health Standards of Care.³ I also relied on my years of research and publication in the field of medical ethics, as set forth in my *curriculum vitae*, and the materials therein.

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

¹ Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria, Florida Agency for Health Care Administration, <https://ahca.myflorida.com/let-kids-be-kids>

² Endocrine Society, Endocrine Treatment of Gender Dysphoric/ Gender- Incongruent Persons: An Endocrine Society Clinical Practice Guideline (September 2017), available at <https://www.endocrine.org/clinical-practice-guidelines/gender-dysphoria-gender-incongruence>

³ World Prof'l Ass'n for Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People (8th ver. 2023), <https://www.wpath.org/publications/soc>

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

THE GAPMS REPORT ERRONEOUSLY CONCLUDES THAT THERE IS LITTLE OR NO EVIDENCE FOR THE BENEFITS OF MEDICAL CARE FOR GENDER DYSPHORIA

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

14. GRADE is a widely accepted framework for developing and presenting summaries of medical evidence and establishing clinical recommendations and guidelines based thereon.⁴ The framework considers the population in question – here, transgender adolescents experiencing gender

⁴ GRADE: Welcome to the GRADE working group. Accessed May 17, 2023. Available at <https://www.gradeworkinggroup.org/#pub>.

dysphoria, and the outcomes desired from clinical intervention – and the alleviation of clinically significant distress associated with such dysphoria. The framework is then used to rank the quality of evidence as applied to the desired outcome to assess the strength of the correlation between the intervention and the desired outcome. The GRADE approach uses four categories to rate the quality of evidence: “high,” “moderate,” “low,” and “very low.” These rankings reflect the extent of confidence that the estimates of an effect are adequate to support a particular clinical decision or recommendation.⁵

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

16. The determination of evidence as low quality does not imply the strength of a particular clinical recommendation. In fact, low quality studies

⁵ Balshem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol.* 2011;64(4):403.

regularly guide important aspects of clinical practice, and the GRADE framework specifically notes that GRADE should not be used to dismiss observational studies or to give absolute priority to RCTs, as it appears the Boards have done here.⁶ Put another way, technically “low quality” evidence can, and often does, support strong clinical recommendations. Further, it is incoherent to suggest that, in the absence of “best-grade” evidence, clinicians should provide no clinical intervention or treatment at all, especially where there is solid evidence that all points in the same direction with respect to showing efficacy of treatment. From a practical perspective, if the standard was that clinical practice guidelines could only issue when there was evidence characterized under the GRADE system as “high quality,” many well-established and effective medical treatments would be barred from use. Indeed, under current ethical standards, doing so would likely constitute medical malpractice.

17. The WPATH SOC and Endocrine Society Guidelines are parallel to countless other practice guidelines and, indeed, enjoy reliance on a robust and evolving literature. The GAPMS report mysteriously departs from the GRADE framework by excluding available evidence as of “low quality.” This appears a calumny more than a reasoned critique. It is, moreover, noteworthy that though the GAPMS document purports to rely on standards for evidence-based medicine, it

⁶ Balshem et al., *supra* note 5, at 402.

neglects to recognize a key aspect of its foundations: “Evidence-based medicine ... is the integration of best research evidence with clinical expertise and patient values.”⁷ Leading scholars of evidence-based medicine have long and consistently made clear the essential role of patient values and clinical judgment in evidence-based medical practice. The role of legislatures in regulating that judgment and practice was, until recently, unthinkable. It is and remains, however, scientifically and ethically illicit. In normal circumstances, the measure in question would seem to compel physicians to commit medical neglect or abandonment and, sadly, do so based on ideology and not evidence.

18. In the context of medical treatment for gender dysphoria in adolescents, the use of an RCT would present serious ethical concerns. The medical care at issue here has been demonstrated, by reliable scientific methods, to be effective in alleviating the distress associated with gender dysphoria and improve mental health outcomes in adolescents. Given that there is broad medical consensus, based on solid, peer-reviewed research that these medical treatments are safe and effective, it would likely be unethical to conduct a randomized, placebo-controlled trial, which would entail the withholding of standard-of-care treatment from a control group of adolescents experiencing gender dysphoria.

⁷ Sackett, D.L., Straus, S.E., Richardson, W.S., Rosenberg, W., Haynes, R.B. *Evidence-Based Medicine: How to Practice and Teach EBM*. (2d ed. 2000).

19. The clinical practice guidelines for treatment of gender dysphoria in adolescents are consistent with guidelines developed in other areas of pediatric care where many interventions are supported solely or primarily by evidence regarded as less than high quality. Much pediatric practice would be utterly undone and out of bounds if the stance revealed in the GAPMS Report were applied to many conditions afflicting adolescents. In pediatric oncology, for instance, numerous interventions are both the only options available and are, as such, embraced by the medical community. The same is true in many other specialties; indeed, the lack of RCT evidence has long been a challenge to the pediatrics community (where one analysis found that “43% [of pediatric practice guidelines] were based on experimental studies, 30% on observational studies, and 27% on expert opinion or no reference).”⁸ The GAPMS report would, similarly, enjoin the use of most if not all off-label medication prescriptions. To be sure, observational and case-control studies “may be the only available or practical information in support of a therapeutic strategy.”⁹ Indeed, this is the case with all

⁸ Isaac, Andre et. al., Quality of Reporting and Evidence in American Academy of Pediatrics Guidelines. *Pediatrics*. April 2013;131(4):732–738. Available at <https://publications.aap.org/pediatrics/article-abstract/131/4/732/31887/Quality-of-Reporting-and-Evidence-in-American?redirectedFrom=fulltext>.

⁹ PDQ Adult Treatment Editorial Board. Levels of Evidence for Adult and Pediatric Cancer Treatment Studies: Health Professional Version. *PDQ Cancer Summaries [Internet]*. October 2022. Available at <https://www.ncbi.nlm.nih.gov/books/NBK65748/>.

rare diseases, for which observational and real-world data are all that is available.¹⁰

It would be medically and ethically impermissible to deny or delay treatment for millions of pediatric patients with a wide range of maladies because state legislatures found fault with the evidentiary bases of available treatments.

Similarly, in Florida, minors frequently receive cosmetic procedures, including breast augmentation, ear surgery, liposuction, and rhinoplasty – with a less-than-optimal evidence base. These procedures are intended to treat no malady and cure no disease.

20. It is worthy of note that an effort to establish a registry that would have improved gender dysphoria evidence was rejected by Florida's Boards of Medicine and Osteopathic Medicine. It is difficult to understand how and why those who are newly concerned about the evidence for gender dysphoria treatment would disdain existing evidence *and* impede efforts to acquire more and better evidence.

21. To my knowledge, the actions of the Florida Boards of Medicine and Osteopathic Medicine in prohibiting health care providers from following clinical practice guidelines or standards of care for the treatment of a particular patient population are unprecedented. No other pediatric clinical guidelines or standards

¹⁰ Liu, Jing et. al., Natural History and Real-World Data in Rare Diseases: Applications, Limitations, and Future Perspectives. *J Clin Pharmacology*. December 2022;62(S2):S38-S55. Available at <https://accp1.onlinelibrary.wiley.com/doi/10.1002/jcph.2134>.

of care have been rejected by the Florida Boards of Medicine and Osteopathic Medicine because the quality of the evidence supporting them is determined to be less than high quality. Permitting these boards to bar health care providers from following clinical practice guidelines or standards of care that are based on less than high quality evidence would subject many pediatric patients to serious harm.

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

Executed on May 17, 2023, in Miami, Florida.



Kenneth W. Goodman, PhD

EXHIBIT A

UNIVERSITY OF MIAMI
Curriculum Vitae

1. Date: February 19, 2023

I. PERSONAL

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

II. HIGHER EDUCATION

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

III. EXPERIENCE

14. Academic:

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

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

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

Faculty Member, Sylvester Comprehensive Cancer Center, 2010-present

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

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

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

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

Director, Florida Bioethics Network, 2004-present

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. Hospital Appointments

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

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

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

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

Member, VAMC Miami Ethics Committee, 1994-2003.

16. Non-academic:

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

17. Military: NA

IV. PUBLICATIONS

18: Books and monographs published

Books

1. Goodman KW. *Ethics, Medicine and Information Technology: Intelligent Machines and the Transformation of Health Care*. Cambridge: Cambridge University Press, 2016.
2. de Velasco RE, Fiore RN, Goodman KW, Moseley R, Spike J, Weldon KM, eds. *Guidelines for Ethics Committees: A Resource for Hospitals, Nursing Homes and Hospices*. Miami: The Florida Bioethics Network, 2011.
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5. Anderson JG, Goodman KW. *Ethics and Informatics: A Case-Study Approach to a Health System in Transition*. New York: Springer Verlag, 2002. Portions adapted as part of "Toward Striking a Balance in Bioinformatics," American Medical Association's online Virtual Mentor, Genethics, March 2001 (<http://virtualmentor.ama-assn.org/2001/03/gnth1-0103.html>).
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7. Coughlin S, Soskolne C, Goodman KW. *Case Studies in Public Health Ethics*. Washington, D.C.: American Public Health Association, 1997. Translated into Mandarin by Xiao Wei as 公共健康伦理学案例研究, Beijing: People's Publishing House 2008 (ISBN 978-7-01-006666-0, R1-05/K584).
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9. Nirenburg S, Carbonell J, Tomita M, Goodman KW. *Machine Translation: The Knowledge-Based Approach*, San Mateo, Calif.: Morgan Kaufmann, 1991.

Chapters

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2. Goodman KW. Confidentiality and Privacy: Traditional Concerns and Digital Challenges. In Hester DM, Schonfeld TL, eds., *Guidance for Healthcare Ethics Committees*, Second Edition, Cambridge: Cambridge University Press, 2022, pp. 85-94.
3. Goodman KW, Miller RA. Ethics in biomedical and health informatics: Users, standards, and outcomes. In Shortliffe, EH, Cimino JJ, Chiang MF, eds., *Biomedical Informatics: Computer Applications in Health Care and Biomedicine*. Fifth Edition. Cham, Switzerland: Springer Nature, 2021, pp. 391-423. (Revised from the Fourth Edition, 2014, below).

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 6. Goodman KW, Birnback DJ. Ethics and plastic surgery practice. In Cohen M, Thaller S, eds., *The Unfavorable Result in Plastic Surgery: Avoidance and Management*, 4th ed., New York: Thieme, 2018, pp. 25-30.
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6. Holt GE, Kett D, Goodman KW. More on an Unconscious Patient with a DNR Tattoo. *New England Journal of Medicine* 2018; 378:875-877. doi: 10.1056/NEJMc1800052. PMID: 29490184.
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9. Kareff S, Goodman K. Ethics in MD/MPH curricula: A case study describing unique considerations for dual-degree students. *MedEdPublish* 2017; 6(2): 2. DOI:<https://doi.org/10.15694/mep.2017.000064>
10. Goodman KW. Introduction: Symposium on ethical issues in data science and digital medicine. *Cambridge Quarterly of Healthcare Ethics* 2017;26(2):326-327. DOI: <https://doi.org/10.1017/S0963180116000906>.
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11. Buttrick S, O’Phelan K, Goodman K, Benveniste RJ. Prospective study of futile care in the neuroscience intensive care unit. Congress of Neurological Surgeons, www.neurosurgery-online.com 2016;63:174.
12. Goodman KW. Addressing ethical issues in health information technology. Guest Editorial. *Cambridge Quarterly of Healthcare Ethics* 2015;24:252-4.
13. Cañete R, Goodman KW. Cuba-US collaboration and the role of bioethics. Letter. *The Lancet* 2015;385 (9972):945.
14. Goodman KW. Health analytics and big data. *Lahey Health Journal of Medical Ethics* 2014;Spring:9-10.
15. Bishop EM, Mandel NS, Brosco JP, Goodman KW, Mechaber AJ, Mechaber HF. Third-Year Medical Student Debrief Groups: Maintaining Empathy in the Clinical Years. Poster, AAMC Group on Student Affairs/Group on Diversity Affairs/Organization of Student Representatives National Meeting, San Diego, April 2014.

16. Goodman KW. Review of *Handbook of Analytic Philosophy of Medicine*, Sadegh-Zadeh, K., Dordrecht: Springer, 2012. *Journal of Biomedical Informatics* 2013;46:782-783, DOI 10.1016/j.jbi.2013.06.005.
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 19. Goodman KW. What would you do? Test yourself on this ethical dilemma. MedScape, Aug. 8, 2012. Available at <http://www.medscape.com/viewarticle/768554>.
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22. Sylvester M, Goodman KW. Patient Confidentiality 2,” in Spandorfer J et al., eds. *Professionalism in Medicine*, Cambridge University Press (2010) pp. 57-60.
 23. Meslin EM, Goodman KW. Bank on it: An ethics and policy agenda for biobanks and electronic health records. Center for American Progress, Science Progress, Feb. 25, 2010, http://scienceprogress.org/2010/02/bank-on-it/#_edn25.
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 25. Cohen DA, Goodman KW, Andrews D. Ethical and educational challenges in reporting clinical significance of a multi-disease gene as illustrated by the methylene tetrahydrofolate reductase (Mthfr) C677t polymorphism (abstract). National Coalition for Health Professional Education in Genetics, annual meeting, Bethesda, September 22, 2009.
 26. Goodman KW, Einspruch NG. The way forward in the world of robotics (letter). *Science* 24 April 2009 324: 463-464. [DOI: 10.1126/science.324_463d]. PMID: 19390022 (Reprinted in Kennedy ML, Kennedy WJ, eds. *Writing in the Disciplines: A Reader and Rhetoric for Academic Writers*. Boston: Pearson, 2012: 361-362.)
 27. Goodman KW, Fiore RN. Toward a research ethics consultation service. *American Journal of Bioethics* 2008;8(3):31-32.PMID: 18570098.
 28. Goodman KW. Privacy as an international value. *Minas faz Ciência* 2008 (November): 32-33. (Published by the Fundação de Amparo à Pesquisa do Estado de Minas Gerais [Foundation for the Support of Research in the State of Minas Gerais (Brazil)].)
 29. Goodman KW. On the growth of ethics programs. In Schrag B, ed. *Developing Relationships: How Ethics Center Can Succeed with Raising Funds*. Adapted papers from an Ethics Center Colloquium, Annual Meeting of the Association for Practical and Professional Ethics, San Antonio, Feb. 21, 2008. APPE: Bloomington, Ind., 2008, pp. 11-13.

30. Goodman KW. Ethics, schmethics: The Schiavo case and the culture wars. *University of Miami Law Review* 61:2007:863-865.
31. Marckmann G, Goodman KW. Introduction: Ethics of Information Technology in Health Care. *International Review of Information Ethics (ERIE)* 2006;5:2-5/http://www.i-r-i-e.net/inhalt/005/0500_full.pdf.
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35. Goodman KW. Commentary: National living wills and local politics. *ASBH Exchange* (newsletter of the American Society for Bioethics and Humanities) 1999; Summer: 6.
36. Goodman KW. Health care ethics. *Responses to an Aging Florida* 1999;Summer: 5-6
37. Goodman KW. Health informatics and the hospital ethics committee. *MD Computing* 1999;16(2):17-20.
38. Goodman KW et al. IRB review: Necessary, nice or needless? (Letter) *Annals of Epidemiology* 1999;9:68-70.
39. Goodman KW. Introduction to informed consent. Part of American College of Medical Genetics Annual Clinical Genetics Meeting workshop (Paradigms for designing informed consent for genetic testing and research), *Genetics in Medicine* 1999;1(2):21 (abstract).
40. Balkany T, Hodges AV, Goodman KW. Additional comments. *Otolaryngology—Head and Neck Surgery* 1998;119(4):312-313.
41. Goodman KW. Ethics of computer prognoses. *Physicians and Computers* 1998;16(2):23-26.
42. Goodman, K. The ethics of CHINs: Community Health Information Networks offer opportunities -- and ethical challenges -- for health care providers. *Physicians and Computers* 1997;15(3):16-19, 23-24.
43. Goodman, K. Business Ethics for Bioethics Committees. *Network News: Newsletter of the Florida Bioethics Network* April 1998: 1-3.
44. Goodman, K. Medical ethics in education, policy review & consultation. *The Record* (Broward County, Florida, Medical Association) 1997;59(5):7-8.
45. Goodman, K. Progress in ethics: from “dilemma fetishism” to genetics and psychiatry. 22nd International Congress on Law and Mental Health, June 1997, Montreal, p. 29 (abstract).
46. Anderson, J, Goodman, K. Ethical issues in informatics and community health. American Medical Informatics Association, Spring Congress, May 1997, San Jose, Calif., Final Program and Abstract Book, p. 99.
47. Coughlin SS, Kass NE, Goodman KW, Pies C. Instruction in Public Health Ethics. American Public Health Association 124th Annual Meeting, Book of Abstracts, 1996, p. 431.

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

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

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

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

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

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

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

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

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

20.b Instructional Media

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

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

Goodman KW. Nurse practitioner education in developmental disabilities, Webinar Series, Florida Developmental Disabilities Council, March 2015 [<https://www.youtube.com/watch?v=NcjbPNIy7k>].

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

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

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

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

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

21. Other works accepted for publication:

V. PROFESSIONAL

22. Funded Research Performed:

Current

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

NSF planning Díaz-Pachón 2021-2022
IUCRC Planning Grant University of Miami: Center for Standards and Ethics in Artificial Intelligence (CSEAI)

Role: Co-investigator, 1%

Previous

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Grant-related Consulting

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

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

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

23. Editorial responsibilities

Study Sections and Review Panels

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

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

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

European Science Foundation / Research Foundation Flanders, 2021

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

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

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

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

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

AHRQ, 2011

Wellcome Trust, UK, 2011 (WT095887RR) grant review

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

Maryland Stem Cell Research Fund Peer Review, 2009.

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

NIH research ethics Study Section, 2002-2006.

National Science Foundation, Ethics Section, 2004, 2005

Reviewer, Alpha-1 Foundation, 2007-2013

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

Referee

- AAMC Southern Group on Educational Affairs, 2014 annual meeting
- *Acta Bioethica* [n, 2009]
- *Acta Tropica*
- *AMA Journal of Ethics* [2018]
- *Ambulatory Pediatrics*
- *American Journal of Bioethics* [n, 2006]
- *American Journal of Industrial Medicine* [2004]
- *American Journal of Ophthalmology* [2018]
- *Annals of the American Thoracic Society* [2013]
- *Annals of Epidemiology* [n, 2008]
- *Applied Clinical Informatics* [2018; 2]
- Association for Practical and Professional Ethics [n, 2016, 2017]
- *Biomed Central Medical Ethics* [2017]
- *BMC Medical Ethics* [2017]
- *Bulletin of the World Health Organization* [2019]
- *Business & Professional Ethics Journal*

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

Other

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

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

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

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

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

External Reviewer

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

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

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

Associate Editor, *Acta Bioethica*, 2010-present

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24. Professional and honorary organizations:

AMIA (American Medical Informatics Association)

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

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

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

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

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

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

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

Member American Association for the Advancement of Science
Member American Medical Informatics Association
Member American Society for Bioethics and the Humanities
Member Association for Practical and Professional Ethics
Member Florida Bioethics Network; Director, 2004-present

25. Honors and awards:

Elected Fellow, The Hastings Center, 2020.

Elected Fellow, American College of Epidemiology, September 2018.

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

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

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

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

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

Inducted Alpha Omega Alpha Medical Honor Society, March 2012.

Honorable Mention, Dorland Health People Awards, October 2011
(<http://accessintelligence.imirus.com/Mpowered/book/vcip11/i6/p1>).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26. Post-doctoral fellowships: NA

27. Other professional activities, service:

2023

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

2022

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

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

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

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

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

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

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

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

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

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

2021

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

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

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

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

2020

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

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

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

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

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

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

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

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

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

2019

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2018

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2017

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

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

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

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

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

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

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

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

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

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

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

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

2016

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

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

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

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

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

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

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

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

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

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

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

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

2015

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

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

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

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

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

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

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

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

2014

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2013

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

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

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

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

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

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

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

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

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

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

2012

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2011

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

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

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

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

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

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

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

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

2010

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2009

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2008

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2007

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2006

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2005

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2004

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2003

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2002

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2001

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2000

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1999

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1998

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Goodman K, et al., panelists, "Doctor, Where Are You? Jewish Ethics and the Health Delivery Revolution," The Jewish Theological Seminary, West Palm Beach, Nov. 22.

Goodman KW. Ethics and politics. Greater Miami Chamber of Commerce, Leadership Miami program, Miami, Dec. 5.

Goodman KW. Ethics, evidence and quality. Dade Association for Healthcare Quality, Miami, Dec. 16.

1997

Goodman K, Informed Consent for Clinical, Cosmetic and Research Procedures, Dermatology Seminar, UM Department of Dermatology and Cutaneous Surgery, Feb. 5.

Panel member, Health Care: Right or Privilege, UMSM 14th Annual Student Council Convention, Feb. 6.

Panel member, Right to Die, Organization for Human Rights, UM School of Law, Feb. 12.

Goodman, KW. Meta-analysis: opportunities and challenges, Combined Endocrinology and Diabetes Grand Rounds, UM Department of Medicine, Feb. 27.

O'Connell, M, Goodman KW. Evidence-based medicine, MD/PhD Grand Rounds, Feb. 24, and April 15, 1997.

Goodman, KW. Archived Samples and Bioinformatics: Lessons from the Banked Tissue and Sera Debate. American College of Medical Genetics, Annual Meeting, Fort Lauderdale, March 2.

Goodman, KW. Ethical Issues in International Occupational Health, American College of Occupational and Environmental Medicine, Annual Meeting, Orlando, May 16.

Goodman KW. Progress in ethics: From "Dilemma Fetishism" to genetics and psychiatry. 22nd International Congress on Law and Mental Health, Montreal, June 19-21.

Goodman KW. Computers, patient outcomes and physician profiling. Broward General Medical Center Grand Rounds, Fort Lauderdale, July 10.

Panelist, Prostate Cancer: To Screen or Not to Screen, Third Annual Florida Epidemiology Meeting, Miami Beach, July 25.

Goodman KW. Clients, Computers and Confidentiality, Florida Council on Aging Florida Aging Network Training Conference, St. Petersburg Beach, Fla., Aug. 25.

Goodman, KW. Ethical Challenges Facing Health Care Professionals. South Florida Case Management Network, Miami, Sept. 10.

Panelist, Neuroscience Grand Rounds on Ethical Problems, UM Department of Neurology, Sept. 12, 1997

Goodman, KW. "Ethical Challenges in Minority and Elderly Recruitment." Increasing Participation of Minorities and Older Americans in Clinical Research, UM/Sylvester Comprehensive Cancer Center, Coral Gables, Fla., Sept. 17.

Goodman, KW. "Findings from the American College of Epidemiology Ethics Survey on the Need for Ethics Guidelines for Epidemiologists," Annual Scientific Meeting, American College of Epidemiology, Cambridge, Mass., Sept. 23, 1997.

Goodman, KW. "Alternative Approaches to Clinical Ethics," Florida Bioethics Network, Seventh Annual Conference, Tampa, Oct. 8, 1997.

Goodman, KW. "Ethical and Social Challenges for Medical Informatics," Tutorial Session, American Medical Informatics Association Fall Symposium, Nashville, Oct. 25.

Goodman, KW., Panel Organizer, "Ethical Issues in Internetable Health Care," American Medical Informatics Association Fall Symposium, Nashville, Oct. 28

Goodman, KW. "The Medical Futility Project," Health Council of South Florida, 1997-98 Board of Directors Retreat, Hawk's Cay, Fla., Oct. 31.

Goodman, KW. "Ethical Issues Concerning the Use of Animals." Animal Studies Training Workshop, VA Medical Center, Miami, Nov. 25.

1996

Goodman, K. Panelist, Are Bioethical Questions Creating More Controversy in Medical Care? Florida Medical Association 1996 Media and Medicine Conference, Orlando, Jan. 25.

Goodman, K., and Moseley, R. Medicine, Morals and the Media: Bioethics Issues in Hospital Public Relations and Marketing. Florida Hospital Association, Orlando, Jan. 26.

Holzman, B., Armstrong, A., Goodman, K. Faculty, Pediatric Bioethics Workshop, Masters of Pediatrics conference, University of Miami Department of Pediatrics, Jan. 29.

Goodman, K. Ethical Issues in Forensic Psychology, South Florida Evaluation and Treatment Center, Florida Department of Health and Rehabilitative Services, Miami, Feb. 2.

Goodman, K. Death in the ICU: It's Not What It Used to Be. Miami Teaching Institute, Greater Miami Chapter, American Association of Critical Care Nurses, Miami, Feb. 9.

Goodman, K. Brain Death, Medical Futility and Other Confusing Concepts: Lessons in Moral Fallibility. Second International Symposium on Brain Death, Havana, Feb. 29.

Goodman, K, and Feltman, D. Ethics, Economics and Managed Care. Advances in Geriatrics VIII, Miami Area Geriatric Education Center (MAGEC), Miami, March 30.

Franzblau, M, Brosco, J., and Goodman, K. Ethical Issues in Health Care: Lessons from the History of Medicine. University of Miami School of Medicine, April 15-26.

Goodman, K. Ethical Issues in Neonatal Nursing. Southeast Florida Association of Neonatal Nurses, Hialeah, May 28.

Goodman, K. The Ethics of Scientific Collaboration. Outcomes Research Group, University of Miami School of Medicine, May 29.

Goodman, K. Ethical Issues in Clinical Research: The Role of Trainees, Department of Urology Grand Rounds, University of Miami School of Medicine, May 31.

Goodman, K. Predicting Death: Can We Do it, and Can Computers Help Us? "End of Life Decisions 1996," Baptist Health Systems of South Florida, Sept. 21.

Goodman, K. Risks, Rules and Ratios: Ethically Communicating about Health and Disease, U.S. Centers for Disease Control and Prevention, Atlanta, Sept. 27.

Goodman, K. Advice on Consent: Where Science and Ethics Meet, U.S. Centers for Disease Control and Prevention, Atlanta, Sept. 27

Goodman, K. Computers in Pediatric Diagnosis and Prognosis: Ethical and Social Issues, UMSM Department of Pediatrics Staff Conference, Oct. 15.

Goodman, K. Ethics Committees: Structure, Function, and JCAHO Requirements. Florida Bioethics Network Sixth Annual Conference, Fort Lauderdale, Oct. 23.

Goodman, K. et al. Panel discussion, What Bothers Me about My Ethics Committee? How We Handle Those Problems, Florida Bioethics Network Sixth Annual Conference, Fort Lauderdale, Oct. 24.

Goodman, K. Can Scoring Systems Determine Futility? Florida Bioethics Network Sixth Annual Conference, Fort Lauderdale, Oct. 25.

Goodman, K. Ethical and Social Challenges for Medical Informatics, tutorial, American Medical Informatics Association fall symposium, Washington, D.C., Oct. 26.

Goodman, K. Ethics and Meta-Analysis, UM Outcomes Research Study Group, Dec. 5.

1995

Goodman, K. Why Ethics in Medicine is not Touchy, Feely, Warm or Fuzzy, Association for the Behavioral Sciences and Medical Education (ABSAME), Naples, Fla., Oct. 7, 1995.

Goodman, K. Why Ethics Matters to Psychology and Psychiatry (Especially When We Have All These Legal Guidelines Floating Around), South Florida Evaluation and Treatment Center (HRS), Miami, July 7, 1995.

Goodman, K. Issues in Publication and Authorship, Grass Foundation Fellowship program, Marine Biological Laboratory, Woods Hole, Mass., June 28, 1995.

Goodman, K. Ethics and Epidemiology, New England Epidemiology Institute and Tufts University, Boston, June 26-30, 1995.

Goodman, K. Restructuring the Health Care System and Tips on How to Improve the Visibility and Viability of Education in the Midst of Change, Florida Medical Association, 121st Annual Meeting, Miami Beach, June 1, 1995.

Goodman, K. Bioethics & Pastoral Care, Jackson Memorial Hospital Department of Pastoral Care program, "The Clergy and the Cancer Patient," May 26, 1995.

Goodman, K. Panelist, AIDS and Suicide: Psychiatrists' Role in End-of-Life Decisions, American Psychiatric Association annual meeting, Miami Beach, May 22, 1995.

Goodman, K. Medical Ethics in the Care of the Elderly, Hartford Generalist Physician Initiative Conference, Miami Beach, April 28, 1995.

Goodman, K. On Progress in Law in Ethics, "Health Care Regulation and Reform" course, Prof. M. Farrell, University of Miami School of Law, April 20, 1995.

Goodman, K., Kinzbrunner, N. A Philosopher and a Physician Discuss Assisted Suicide, "Decisions Near the End of Life," Education Development Center and the Hastings Center, Miami, March 24, 1995.

Goodman, K. Ethics of Animal Research, Animal Research Training Session, Veterans Affairs Medical Center, Miami, March 21, 1995.

Goodman, K. et al. Moderators, Legislative Panel: "Reshaping Health Care in the '90s and Beyond: A Legislative Symposium on Health Care Reform," sponsored by the Health Council of South Florida, Miami Panelists: Rep. John F. Cosgrove, chair, House Insurance Committee; State Sen. Alberto Gutman, chair, Senate Health Care Committee; Rep. J. Alex Villalobos, chair, Dade County Legislative Delegation; Miami, March 2, 1995.

Goodman, K., Needell, M. Ethics and Risk Management, Parkway Regional Medical Center, North Miami Beach, March 2, 1995.

Goodman, K.. Moot Court judge, University of Miami School of Law, Feb. 25, 1995.

Holzman B, Goodman K, Armstrong D. Pediatric bioethics. UM Department of Pediatrics, "Masters of Pediatrics," Miami, Jan. 22.

Goodman K. When enough is enough: Rationing, futility and assisted suicide. Leadership Miami, "Our Community's Health: Everyone's Business," Miami, Jan. 21.

Goodman K. Ethical considerations for policies dealing with drug seekers, American College of Emergency Physicians, State Chapter of California, "Emergency Medicine at the Ahwahnee," Yosemite, Calif., Jan 14, 1995.

1994

Goodman, K. Ethical Issues in Correctional Health Care, Florida Department of Corrections Office of Health Services, 1994 Workshop, Daytona Beach, Fla., Nov. 16, 1994.

Goodman, K. Ethics, Computers and Epidemiology, Harvard University School of Public Health, Department of Epidemiology, Cambridge, Mass., Oct. 12.

Goodman K. Problems and solutions in publication and authorship. Schepens Eye Research Institute, Harvard Medical School, Cambridge, Mass., Oct. 11.

Goodman K. Ethics and computing in orthopaedics, UM Department of Orthopaedics and Rehabilitation Grand Rounds, Miami, Sept. 29.

Goodman K. Foundations of medical ethics: History, theory and principles of end-of-life issues, Florida Bioethics Network Annual Conference, Orlando, Sept. 21.

Goodman, K. Ethical Issues in Caring for the Elderly: Advance Directives and Decisions in the Absence of Directives, Miami Area Geriatric Education Center, geriatric training program, Miami, May 25; repeated Aug. 31.

Labadie, G., Goodman, K. Ethical Issues in AIDS: Confidentiality and Teaching Perspectives, University of Miami School of Nursing, HIV in the Nursing Curriculum conference, May 20, 1994.

Goodman, K. Computers, Medical Decision-making and Confidentiality, presentation to University of Florida College of Medicine (Shands Hospital Ethics Committee Rounds), Gainesville, Fla., April 8, 1994.

Goodman, K. (Panel chair) Issues Brought to the IRB on HIV/AIDS Research and Confidentiality Issues, Society of Research Administrators, South Florida Chapter, "Outlook '94--A Symposium on AIDS Prevention," VAMC-Miami, March 16, 1994.

Goodman, K. Ethical Issues in Health Care Reform: The Lessons from Florida, presented to Florida Medical Association, "Spring Break for CME," Palm Beach Gardens, Florida, March 3, 1994.

Goodman K. Computer assisted decision making in the ED, American College of Emergency Physicians, State Chapter of California, "Emergency Medicine at the Ahwahnee," Yosemite, Calif., Jan 13, 1994.

1993

Goodman, K. Uncertainty and ethics in medical computing, Second Annual Computers in Health Care Conference, Delaware State Hospital, New Castle, Delaware, Nov. 3, 1993.

Goodman, K. Toward a Unified Code of Ethics in Epidemiology, 26th annual meeting of the Society for Epidemiologic Research, Keystone, Colo., June 17, 1993.

Goodman, K. Major Uses of Computerized Diagnostic Systems and the Ethical Questions they Raise. Annual meeting of the Florida Medical Association, Miami Beach, May 8, 1993.

Goodman, K. Ethical Issues in Endocrinology, University of Miami Department of Medicine combined Endocrinology and Metabolism Grand Rounds, April 15, 1993.

1992

Pennell, J.P., Goodman, K. Should Sovereign Immunity be Extended to Private Physicians? Presentation to Society for Health and Human Values annual meeting, Memphis, November 1992.

Goodman K. Cultural relativism, truth-telling and informed consent. Transcultural Nursing in Retrospect and Prospect, 18th Annual Transcultural Nursing Society Conference, Miami, Oct. 23, 1992.

Goodman, K. Ethical Correlates of Physician-Patient Conflict, University of Miami Department of Obstetrics-Gynecology Grand Rounds, Sept. 23, 1992.

Goodman, K. Why Abortion Might Be Wrong But Should Be Legal, University of Miami Department of Philosophy / Friends of Philosophy series, Feb. 26, 1992.

Goodman, K. Ethical Issues in Computational Meta-Analysis, presented to American Association for the Advancement of Science annual meeting, Chicago, Feb. 7, 1992.

Goodman, K. Bioethicists, Journalists and Public Policy: The Philosopher Cops, presented to National Conference on Ethics & the Professions, Gainesville, Fla., Jan. 31, 1992.

Goodman, K. Case-Based Ethical Analysis in Dermatology, University of Miami Department of Dermatology Grand Rounds, Jan. 15, 1992.

1990

Goodman, K. Ethics and research in publishing, University of Pittsburgh College of Medicine Student Publishing Workshop, Graduate School of Public Health, Nov. 27, 1990.

Goodman, K. Ethical Issues in Medicine and Communication, presented to the University of Pittsburgh College of Medicine Center for Medical Ethics, Nov. 8, 1990.

Goodman, K. Doing Good and Doing Well: Questions of Ethics and Economics, presented to Hospital Council of Western Pennsylvania, Erie, Oct. 4, 1990.

Goodman, K., Nirenburg S. To Save the Semantic Phenomena: Machine Translation and Interlingua Texts, presented at the Fifth Annual Computers and Philosophy Conference, Stanford University, Palo Alto, Calif., August 9, 1990.

Goodman, K. Communicating Change: Experts and Progress in Medicine, Spring Conference of the Society for Health and Human Values, Hershey, Pennsylvania, April 20, 1990.

Goodman, K. Ethical, Social, Legal and Economic Responsibilities in Medical Rehabilitation, Panel discussion with Arnold S. Relman, Editor, *New England Journal of Medicine*, sponsored by Harmarville Rehabilitation Center, Pittsburgh, March 20, 1990.

1989

Goodman, K., invited participant, Professional Ethics in Higher Education: Methods, Theories, Practices, The Poynter Center for the Study of Ethics and American Institutions; Bloomington, Ind. Sponsored by the Harvard Program in Ethics and the Professions, Indiana University-Bloomington CBiomedicalhancellor, The Lilly Endowment and the Poynter Center, July 5-8, 1989.

Goodman, K. Kant's Categories as Semantic Primitives, 34th Annual Conference of the International Linguistic Association, New York, April 18, 1989.

1987

Goodman, K. Theoretical terms, Florida Philosophical Association 33rd Annual Meeting, St. Petersburg, Nov. 14, 1987. FPA award for best graduate student paper.

VI. TEACHING

28. Teaching awards received

29. Teaching specialization:

2022

"Ethics in Public Health," University of Miami Miller School of Medicine, spring

2021

"Ethics in Public Health," University of Miami Miller School of Medicine, spring

"Research Ethics," University of Miami Miller School of Medicine, spring; with others,

2020

"Research Ethics," University of Miami Miller School of Medicine, spring; with others,

2019

"Professional Ethics, Law and Medicine," University of Miami School of Medicine; winter, spring.

Hospitals Health Care Services and Access: An Interdisciplinary Inquiry, University of Miami School of Law; spring. One of many faculty members.

"Research Ethics," University of Miami College of Arts and Sciences, College of Engineering, etc.; winter.

2018

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

Hospitals Health Care Services and Access: An Interdisciplinary Inquiry, University of Miami School of Law, spring 2018. One of many faculty members.

"Research Ethics," University of Miami School of Medicine and College of Arts and Sciences (varia).

"Research Ethics," University of Miami School of Medicine (autumn).

2017

CTI-603 Research Ethics (CTSI MA program, with Joanna Johnson) (spring)

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

"Research Ethics," University of Miami school of Medicine and College of Arts and Sciences (varia).

"Research Ethics," University of Miami School of Medicine, (autumn) (CTI-603, ie, special CTSI course).JohJoh

2016

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

2015

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

2014

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

2013

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

"The Idea of the Hospital," University of Miami School of Law, spring 2013. One of many faculty members.

2012

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

"The Idea of the Hospital," University of Miami School of Law, spring 2012. One of many faculty members.

2011

"Knowledge and Evidence in Medicine," University of Miami Department of Philosophy (spring)

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

"The Idea of the Hospital," University of Miami School of Law, winter 2011. One of many faculty members.

2010

"Bioethics," University of Miami Department of Philosophy (spring)

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter, spring).

2009

"Bioethics," University of Miami Department of Philosophy (spring)

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter).

"Clinical Ethics" (with D. Buckner), University of Miami Department of Medicine / medicine clerkship (all semesters).

2008

"Bioethics," University of Miami Department of Philosophy (spring)

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter).

"Clinical Ethics" (with D. Buckner), University of Miami Department of Medicine / medicine clerkship (all semesters).

2007

"Social and Ethical Issues in Computing," University of Miami Departments of Computer Science and Philosophy (spring).

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter).

"Clinical Ethics" (with D. Buckner), University of Miami Department of Medicine / medicine clerkship (all semesters).

2006

"Bioethics," University of Miami Department of Philosophy (spring)

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter).

Other: "Patient Safety Course," University of Miami School of Medicine, faculty member, "Error Disclosure and Patient Centeredness" lecture.

"Clinical Ethics" (with J.P. Pennell), University of Miami Department of Medicine / medicine clerkship (all semesters).

2005

"Bioethics," University of Miami Department of Philosophy (fall).

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter).

"Clinical Ethics" (with J.P. Pennell), University of Miami Department of Medicine / medicine clerkship (all semesters).

2004

"Environmental Ethics," University of Miami Department of Philosophy (spring).

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter).

"Clinical Ethics" (with J.P. Pennell), University of Miami Department of Medicine / medicine clerkship (all semesters).

2003

"Bioethics," University of Miami Department of Philosophy (spring).

"International Health Policy and Ethics" (INS 572 with S. Porcelain), University of Miami School of International Studies (spring).

"Professional Ethics, Law and Medicine," University of Miami School of Medicine (winter).

"Research Ethics," University of Miami Schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Clinical Ethics" (with J.P. Pennell), University of Miami Department of Medicine / medicine clerkship (all semesters).

2002

"Professional Ethics," University of Miami Department of Philosophy (spring).

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Medical Ethics," University of Miami School of Medicine, co-design and coordinate new ethics curriculum.

"Clinical Ethics" (with J.P. Pennell), University of Miami Department of Medicine / medicine clerkship (all semesters).

2001

"Bioethics," University of Miami Department of Philosophy (spring)

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Clinical Ethics" (with J.P. Pennell), University of Miami Department of Medicine / medicine clerkship (all semesters).

1999

"Ethics, Epidemiology and Public Health," University of Miami School of Medicine, Department of Epidemiology and Public Health (spring).

"Bioethics," University of Miami Department of Philosophy (spring)

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Clinical Ethics" (with J.P. Pennell), University of Miami Department of Medicine / medicine clerkship (all semesters).

1998

"Ethics, Epidemiology and Public Health," University of Miami School of Medicine, Department of Epidemiology and Public Health (spring).

"International Health Policy and Ethics" (with S. Porcelain), University of Miami School of International Studies (spring).

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Clinical Ethics" (with J.P. Pennell and M.H. Needell), University of Miami Department of Medicine / medicine clerkship (all semesters).

1997

"Bioethics," University of Miami Department of Philosophy (spring)

"International Health Policy and Ethics" (with S. Porcelain), University of Miami Graduate School of International Studies (spring).

"Medical Informatics" (with others), University of Miami departments of Radiology and Electrical Engineering (spring).

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Ethics and Epidemiology," New England Epidemiology Institute and Tufts University, Medford, MA (summer).

"Clinical Ethics" (with J.P. Pennell and M.H. Needell), University of Miami Department of Medicine / medicine clerkship (all semesters).

"Ethical Values in Health Care: Lessons from the Nazi Era," UM School of Medicine Senior Elective, with Drs. Michael Franzblau and Jeffrey Brosco.

1996

"Ethics and Epidemiology," University of Miami School of Medicine, Department of Epidemiology and Public Health (fall).

Dissertation Seminar, University of Miami Graduate School of International Studies (spring).

"Ethics and Epidemiology," New England Epidemiology Institute and Tufts University, Medford, MA (summer).

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

"Clinical Ethics" (with J.P. Pennell and M.H. Needell), University of Miami Department of Medicine / medicine clerkship (all semesters).

1995

"Health Care Reform: Policy, Structure, Ethics" University of Miami School of Nursing (fall and spring).

"Ethics and Epidemiology," University of Miami School of Medicine, Department of Epidemiology and Public Health (fall).

"Ethics and Epidemiology," New England Epidemiology Institute and Tufts University, Medford, MA (summer).

"International Health Policy and Ethics" (with S. Porcelain), University of Miami Graduate School of International Studies (spring).

"Professional Ethics," University of Miami Department of Philosophy (spring).

"Clinical Ethics" (with J.P. Pennell and M.H. Needell), University of Miami Department of Medicine / medicine clerkship (all semesters).

"Research Ethics," University of Miami Schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

1994

"Health Care Reform: Policy, Structure, Ethics" University of Miami School of Nursing (spring).

"Computers, Ethics and Society," University of Miami Freshman Seminar series (fall).

"Clinical Ethics" (with J.P. Pennell and M.H. Needell), University of Miami School of Medicine, Department of Medicine / medicine clerkship (all semesters).

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

1993

"Health Care Organization, Policy and Ethics," University of Miami Freshman Seminar series (fall).

"Clinical Ethics" (with J.P. Pennell and M.H. Needell), University of Miami School of Medicine, Department of Medicine (all semesters).

"Research Ethics," University of Miami schools of Medicine, Arts and Sciences and Marine and Atmospheric Sciences (varia).

1992

"Clinical Ethics," (with others) University of Miami School of Medicine, Department of Medicine; third-year medical students on Medicine clerkship.

1991

"Professional Writing," Duquesne University Department of Communication (spring).

"Business Ethics," Duquesne University School of Business and Administration (summer).

1990

"Professional Writing," Duquesne University Department of Communication (fall).

1989

"Professional Writing," Duquesne University Department of Communication (fall).

1988

"Professional Writing," Duquesne University Department of Communication (fall).

1985

"Introduction to Logic," University of Miami College of Arts and Sciences, Department of Philosophy (fall, spring)

1984

"Introduction to Logic," University of Miami College of Arts and Sciences, Department of Philosophy (fall)

30. Thesis and dissertation advising/post-doctoral student supervision:

- Heleana Theixos, doctoral dissertation, "[Moral Injury in Contemporary Ethics: The Application of a Socratic Idea](#)," Philosophy, 2014-2016, committee chair
- John Pinkston, doctoral dissertation, "[Evidence And Hypothesis In Clinical Medical Science](#)," Philosophy, 2014-2016, committee member
- Wanda Castro, doctoral dissertation, "The feminization of HIV/AIDS in the Republic of South Africa: Examining the influence of socio-economic, political and cultural determinants, Epidemiology, 2006-2011; committee member
- Matthew Schuh, doctoral candidate, Philosophy, 2008; committee member
- Jeremy Morris, doctoral candidate, Philosophy, 2006-2007; committee member
- Nenad Popovic, doctoral candidate, Philosophy, 2005-2006; committee member
- Rajdeep Singh Jolly, Decisional autonomy and Indian sex selection, *magna cum laude* candidate, UM College of Arts & Sciences/Philosophy, 2003; thesis co-adviser
- Sophia S. Chutkan, master of science thesis, Nutrition and Dietetics, Florida International University, 2002-2003; committee member
- Marguerite Purnell, doctoral candidate, Nursing, 2001-2003; committee member
- Maritza Flores, doctoral dissertation, "[The application of the biomedical model and computer technology in decision-making mental care diagnosis and treatment](#)," Sociology, 2001-2003; committee member
- Ruben Rabinsky, NIEHS postdoc, 2001-2003; committee member
- Yvette Pearson, doctoral candidate, Philosophy, 2001-2002; committee member

VII. SERVICE

31. University committee and administrative responsibilities:

Member, UHealth End-of-Life Taskforce, 2020-present

Member, Covid-19 Vaccine Allocation Committee, 2020-

Member, Scientific Misconduct Committee Pool, 2018-2020.

Member, Professional Activity Review Committee (CN), 2010-present; manager/coordinator, 2016-present.

Examiner, BIOT 6006, Bioethics, Biosafety and Intellectual Property Rights in Biotechnology, University of the West Indies, St. Augustine Campus, Trinidad and Tobago, 2016-2018.

Member, Academy of Medical Educators, 2012-present.

Member, UM College of Arts and Sciences graduate faculty, 2012-present.

Member, University of Miami Center for Computational Science, 2011-present.

Member, University of Miami Conflict of Interest Committee, 2010-present.

Member, University of Miami Task Force Committee, Civic Engagement Project, Office of the Senior Vice Provost, 2010-present.

Member, University of Miami Embryonic Stem Cell Research Oversight Committee, 2009-2011.

Member, Faculty Steering Committee, University of Miami Jay Weiss Center for Social Medicine and Health Equity, 2007-present.

Member, University of Miami Medical Group Clinical Operations committee, 2006-2009.

Member, University of Miami Faculty Senate Hearing Panel, 2004-2014.

Member, Jackson Memorial Hospital/UM HIPAA Steering Committee, 2001-2005.

Member, Responsible Conduct of Research Educational Initiative Committee, 2001-2005.

Member, University of Miami core faculty for Human Subjects Protection Seminars, 2001-present

Member, University of Miami Advisory Group for Education in Human Subjects Protections, 2001-2005.

Faculty Advisor, Ethics Society, UM undergraduate service organization, 1994-present.

Member, Bioethics Committee, University of Miami / Jackson Memorial Hospital, 1992-Present. Chair as of July 2007.

Member, Pediatric Bioethics Committee, University of Miami / Jackson Memorial Hospital, 1992-Present.

Member, Jackson Memorial Hospital Transplant Center, Transplant Emergency Panel, November 2008-Present.

Member, Human Studies Subcommittee (IRB), Veterans Affairs Medical Center, Miami, 1992-2001.

Member, Ethics Committee, University of Miami Hospitals and Clinics/Sylvester Comprehensive Cancer Center, 1996-Present; vice chair, 2000-present.

Member, Fetal Board Registry, University of Miami Department of Obstetrics and Gynecology, 1993-1999.

Member, Medical Sciences Subcommittee for the Protection of Human Subjects (IRB), University of Miami/Jackson Memorial Hospital, 1994-2000; alternate, 2000-2003.

Director, Clinical and Research Ethics Education, University of Miami Hospital and Clinics / Sylvester Comprehensive Cancer Center, 1994-present.

Member, Steering Committee, University of Miami Medical Informatics Programs, 1995-1998.

Member, Steering Committee, Outcomes Research Group, 1996-1998.

Preceptor, Clinical Skills Program, University of Miami Department of Medicine, 1992-2000.

Member, Clinical Pastoral Education Professional Advisory Group, Jackson Memorial Hospital, 1993-Present.

Member, Animal Studies Subcommittee, Veterans Affairs Medical Center, Miami, 1994-Present.

Member, Animal Studies Subcommittee, University of Miami, 1994-Present.

Member, Computers in Medical Education committee for LCME accreditation, 1994.

Member, Information Systems Ethics Committee, Jackson Memorial Hospital, 1994-1996.

31a. Other Misc. UM/JMH/VA Contributions

2022

Goodman KW. Big Data, Artificial Intelligence and Privacy in the 21st Century. UHealth Compliance, International Data Privacy Day, January 28.

Goodman KE. Ethics, Research and Learning Health Care Systems. Sylvester Comprehensive Cancer Center, University of Miami Miller School of Medicine, March 23.

2021

Goodman KW, moderator, Theological Perspectives on Organ Donation, Multifaith Council, University of Miami, March 11.

Del Rio C, Goodman KW, Ross LF. A National Conversation: Should Covid-19 Vaccines Be Mandatory on College Campuses? With UM President Julio Frenk, Miller School of Medicine Dean Henri Ford and Department of Medicine Chair Roy Weiss. March 17, University of Miami Webinar,

2018

Goodman KW. Futility, computational decision support and ethics: Why the future of surgery is not what it used to be. University of Miami Miller School of Medicine Department of Surgery, Grand Rounds, March 29.

Goodman KW. Keynote speech. MD/MPH Rose Ceremony, May 25.

2017

Goodman K. Ethics introduction. Compliance and Ethics Week training, November 7, 8 and 9, University of Miami Medical, Marine and Gables campuses.

2015

Goodman KW. Guest speaker. MD/MPH Class of 2018 Anatomy Rose Ceremony, UM Miller School of Medicine, May 18.

Goodman KW. Ethics and leadership. Leadership Development in Neurodevelopmental Disabilities (LEND) Project, UM Miller School of Medicine, Department of Pediatrics, May 15.

2014

Goodman KW. Ethical issues in academia. Faculty Roles and Responsibilities, University of Miami School of Nursing and Health Studies, January 8.

2013

Goodman KW. Access to health care: how ethics should influence public policy. Friends of Philosophy, UM Department of Philosophy, February 13.

Goodman KW. Strategic data sharing by ordinary people: Translational science's reliance on trust and reciprocity. Miami CTSI Translational Science Institute Seminar Series, November 20.

Goodman KW. Ethics, translational science and the IRB: The future is (still) not what it used to be. IRB Grand Rounds, University of Miami, December 10.

2012

Panelist, Miami Council for International Visitors and U.S. Department of State, delegation from Zambia on media freedom, licensing of journalists, etc. UM School of Communication, March 8.

Moderator, HealthCanes, presidential debate, October 1.

2011

Goodman KW. Ethics and translational research: New challenges in genetics, public policy and health information technology. Miami Clinical and Translational Science Seminar Series, UM Miller School of Medicine, November 9.

Goodman KW. Conflicts of interest. UM Miller School of Medicine, Teaching Professionalism Series, March 7.

Goodman KW Ethics in cancer care. Surgical oncology fellows, SCCC, June 8.

2010

Goodman KW. Clinical ethics. UM Division of Gastroenterology, January 28

Goodman KW. Wireless pediatrics: Ethics and the role of personal health records. Clinical Research Forums in Pediatrics, UM Division of Pediatric Clinical Research, March 3.

2009

Panelist, of 5. Brands, cultures and globalization. University of Miami School of Business Global Business Forum, January 16.

Goodman KW. Pediatric contributions to biobanks. Clinical Research Forums in Pediatrics, Division of Pediatric Clinical Research, UM Miller School of Medicine, January 28.

Goodman KW. Ethics and Information Technology. Department of Electrical and Computer Engineering Seminar Series, University of Miami College of Engineering, February 4.

Panelist, of 5. Academic Integrity Forum. University of Miami Undergraduate Honor Council, April 15.

Special seminar for Kenyan and other journalists specializing in HIV and medical reporting, on ethics and science writing, UM School of Communication, April 29.

Goodman KW. Stanford Food for Thought Dinner Series, Stanford Residential College, Nov. 9.

Goodman KW. Awkward research: sects, sex and drugs. UM Human Subjects Protection Seminar, Nov. 10.

2008

Goodman KW. Clinical ethics. UM Division of Gastroenterology, Jan. 24.

Goodman KW, Wilkinson JD, Pericak-Vance M. Ethics and genomics panel. 34th Eastern-Atlantic Student Research Forum, UM Miller School of Medicine, Feb. 29.

Goodman KW. Digital genetics and the future of pediatrics: The role of ethics. UM Department of Pediatrics Clinical Research Forum, March 5.

Panelist, of 5. Global Climate Change: Your Health. (National Public Health Week activity.) UM Department of Epidemiology and Public Health, April 7.

Panelist, of 4. Climate change projections: Communicating uncertainty without losing the message. Rosenstiel School of Marine and Atmospheric Sciences, May 8.

Goodman KW. Stem cell research: Issues in ethics, science and public policy. Osher Lifelong Learning Institute, September 24.

2007

Panel discussion on codes of ethics in public relations. With International Public Relations Association President Philip Sheppard; Jay Black, Poynter Jamison Media Ethics Chair, University of South Florida-St. Petersburg; and Roger Bolton, President of the Arthur W. Page Society. Feb. 20, UM School of Communication.

Goodman KW. Moral responsibility of Holocaust/Legacy Project survivors, JUS421 (M. Sokoloff), April 12.

Panel, Academic Integrity, with Anita Cava, co-director, UM Ethics Programs, and Katie Meier, UM women's basketball coach. Undergraduate Honor Council, Academic Integrity Week, April 17.

Goodman KW. Conflict and consent: Managing disclosure in human subjects research. UM HSRO Human Subjects Research Symposium, May 11.

Goodman KW. Clinical and research ethics. Core Curriculum for Oncology Fellows. Sylvester Comprehensive Cancer Center, Aug. 7.

Cava A, Goodman KW. Community academic expectations. Graduate Student Orientation, Coral Gables, Aug. 16.

Goodman KW. STRIVE student group leadership facilitator, Coral Gables, Oct. 7.

Goodman KW. Ethics and leadership. Freshmen Leadership Academy, Butler Center for Volunteer Service & Leadership Development, Coral Gables, Oct. 15.

2006

Presentation to International Commission on Holocaust Era Insurance Claims (ICHEIC) Service Corps, Miller Center for Contemporary Jewish Studies, April 10.

Presentation to Department of English, Prof. Joanna Johnson, composition.

2005

Goodman KW. Clinical ethics. UM Division of Gastroenterology, Jan. 27.

Goodman KW. Ethics in plastic and reconstructive surgery, UM Department of Surgery, Division of Plastic and Reconstructive Surgery, May 18.

Goodman KW. Error disclosure and patient centeredness. UM Department of Anesthesiology, June 7.

Goodman KW. Research or surveillance? The case of bioterror preparedness. UM Human Subjects Research Forum, August 30.

Goodman KW. The role of ethics in Sponsored Programs. UM Sponsored Programs Education Center, Dec. 15.

2004

Goodman KW. Clinical ethics. UM Division of Gastroenterology, Jan. 22

Goodman KW. The Terri Schiavo tragedy and the use of ethics committees. Ryder Trauma Center TICU nurses, Feb. 10.

Goodman KW. What IRBs need to know about evidence-based practice. UM Human Subjects Research Forum, March 30.

Goodman KW, panelist, Ethics, Reporting and Politics, UM School of Communication and South Florida chapter, Society of Professional Journalists, UMSoc, April 27.

Goodman KW. Questions of ethics. Atlanta Hurricane and Alumni Club, Atlanta, May 5.

Goodman KW. Ethical issues in HIV/AIDS. Visiting speaker, AIDS as a Public Health Issue (EPH583), Department of Epidemiology and Public Health. July 12

Goodman KW. Some ethical issues in hematology/oncology. SCCC didactic conference, July 14.

Goodman KW Research ethics and integrity. UM Department of Dermatology & Cutaneous Surgery, Aug. 27.

Goodman KW. Think about it, talk about it: A discussion on ethics. UM Honor Council, Nov. 17.

Goodman KW. Bioethics and nursing practice. UM Professional Development and Training Office, Dec. 16.

2003

Goodman KW. Ethics and education research II. UM School of Education, Center for Research, January 29.

Panelist. Oceans and Human Health: Risks and remedies from the sea, Town Meeting, National Institute for Environmental Health Sciences and UM Rosenstiel School of Marine and Atmospheric Sciences, Key Biscayne, Feb. 27.

Goodman KW. Foundations of ethics. UM Department of Orthopaedics and Rehabilitation, residents' rounds, March 20.

Panelist. Artificial Intelligence: Ambition and Ethics. UM Solutions and Ethics Society student groups. March 27.

Goodman KW. Do-not-resuscitate orders – and issues. Sylvester Comprehensive Cancer Center nursing staff, April 29.

Goodman KW. Legal issues in end-of-life care, Sylvester Comprehensive Cancer Center EPEC series, June 24.

Goodman KW. Ethics and evidence-based practice. VAMC Miami Medical Center, Research Committee for Nursing, An Evidence-Based Practice, Dec. 4

2002

Panelist, Solutions 2nd Annual Interdisciplinary Symposium, “Science: The Double-Edged Sword,” with Luis Glaser, Joyce Schuld, and David Wilson, with Asma Uddin moderating, March 2.

Goodman K, Making sense of consent: Readability, comprehension and the consent process. Office of Research IRB human subject protection/IRB series, March 26.

Goodman K, Evidence-based practice and human subjects research: Oh, great: More stuff for IRBs to have to worry about. Office of Research IRB human subject protection/IRB series, April 9.

Goodman K. Death and dying. Department of Surgery, Division of Trauma/Surgical Critical Care, April 26.

Goodman K. Discussant, “Local growth coalitions, environmental groups and air pollution,” by George Gonzalez, American Politics Research Workshop, UM Political Science Department, May 15.

Goodman K. Ethics-schmethics – or practical strategies for IRB review? UM IRB “A,” June 17; “B,” Aug. 5.

Goodman K. Intro to ethics. Research in Ecology 2002, a UM-Miami-Dade County Public Schools program, under a Howard Hughes Medical Institute grant, Aug. 1.

Goodman K. Death, dying and ethics in pediatrics, UM/JMH Pediatric Noon Conference, Aug. 5.

Goodman K. Questions of ethics, The Audrey R. Finkelstein Experience, Alumni Week, Oct. 11.

Goodman K. What HIPAA will mean for IRBs and researchers. VAMC Miami, Research: Stimulus for Change, Nov. 8.

Sandoval C, Goodman K. Physician-assisted suicide, EPEC Series, UMHC/SCCC, Dec. 17.

2001

Panelist, “En/gendering Sex, Session III: Testing women: Sex and gender in the lab,” Solutions student group, April 11.

Goodman KW. Stem cells: Ethical, legal and policy issues. UM Institute for Retired Professionals, Oct. 4.

Goodman KW. End-of-life ethical issues. Jackson Memorial Hospital Clinical Pastoral Education Program, Nov. 13.

Goodman KW. Ethical issues in use of animal models in surgical procedures. VAMC Animal Studies Training Workshop, Nov. 29.

Panelist, “Ethical dimensions of the post-September 11 milieu,” UMSM Council on Honorable and Professional Conduct, Dec. 11.

Goodman KW. Policy, justice and international studies: Why ethics matters and why you should care, commencement address, UM School of International Studies, Dec. 13.

2000

Goodman K. Ethics: Why it matters, what it's good for and why you should care. Family Weekend 2000, Department of Student Life, Coral Gables, Oct. 6.

Panelist, "Animal Rights," Humans Helping Animals student group, Coral Gables, Nov. 15.

32. Community activities:

2021

Goodman KW. Guardianship in Residential and Social Settings: Ethical Challenges. Florida State Guardianship Program, Annual Ethics Symposium, April 16.

Godman KW, et al. COVID-19 Vaccine: Issues in Development and Distribution, Women's Healthcare Executive Network of South Florida, Videoconference panel, March 11.

Goodman KW. Interviewer of director and lead actor, *In the Name of the Daughter*, Miami Jewish Film Festival, March 4.

2019

Goodman KW. Pediatric consent for adult-onset genetic malady testing: ethics, education and expertise. South Florida Clinical Genetics Group, Hollywood Memorial Hospital, May 22.

2013

Goodman KW. What would you do? Everyday ethical dilemmas. JFK Medical Center, Challenges for the Hospital Ethics Committee, Atlantis, Florida, October 18.

Goodman KW. DNR vs. AND. Vitas Hospice Corp. Fort Lauderdale, October 18.

2012

Goodman KW. Advance directives and the Florida journey. Integrating Advance Directives, Mercy Hospital, Miami, October 27.

Goodman KW. Dying is not what it used to be: Ethics, technology and the role of the courts. Dade County Bar Association Probate and Guardianship Committee, December 6, Miami.

2010

Goodman KW. Moderator, ethics discussion following screening of *For My Father* at Miami Jewish Film Festival, Coral Gables, Fla., Jan. 17.

Goodman KW. Professionalism and the law for psychologists. Miami Area Geriatric Education Center, Miami, April 16.

Goodman KW. Ethics, science and society: New challenges for the 21st century. Miami Science Museum, Senior Summer Science Series, July 21.

Giles GJ, Goodman KW, Heberer P. Bioethical Responsibilities in the 21st Century, Deadly Medicine in the Nazi Era, U.S. Holocaust Memorial Museum, Boca Raton Regional Hospital, November 4.

2009

Goodman KW. Ponencia: Posibilidades de desarrollo de la bioética en el Estado de la Florida. New Professions Technical Institute, Miami, February 13. (Venezuelan community activity)

Goodman KW. Democracy, Taxes and Government Integrity: Why this Ethics Stuff Really Matters, City of Coral Gables, Boards and Committees Seminar, October 2.

2008

Goodman KW, Participant, Career Day, Feb. 13, and Contemporary Issues in Science, MAST Academy, Miami-Dade County Public Schools, Feb. 20.

Centorino J, Goodman KW, Myers R. Ethics, civility and effective penalties (panel discussion). League of Women Voters, Miami, March 26.

Goodman KW. Eugenics. Baptist Health South Florida, Baptist Hospital, Miami, August 27.

Goodman KW. Practical ethics, vulnerable populations and public policy: Opportunities and obligations. Guardian Association of Pinellas County, St. Petersburg, September 19.

Goodman KW. Access, justice and moral responsibility: Ethical challenges in health care reform. Public Field Hearings on the Health Care Crisis, Rep. John Conyers, chair, Miami, September 20.

2007

Goodman KW. Speaker, Riviera Ladies Day Luncheon, Riviera Country Club, Coral Gables, March 15.

Goodman KW. Scholar in Residence, Temple Beth Ahm Israel, Cooper City, March 16-17.

Goodman KW. Ethics, boundaries and mental health social work. Miami-Dade Area Health Education Center, Miami, March 21.

Goodman KW. Facilitator, "Guardianship Ethics" and "Sex in Nursing Homes: Managing Questionable Capacity and the Desire for Physical Intimacy," Academy of Florida Elder Law Attorneys "Elder Concert," Ft. Lauderdale, March 23.

Goodman KW. Ethics and employee assistance programs. Employee Assistance Association Professionals, Annual Conference, South Florida Chapter, Fort Lauderdale, March 30.

Goodman KW. Who owns life? Genetic research: Ethical perspectives. Broward Region of Hadassah and U.S. Department of Energy, Fort Lauderdale, June 7.

2006

Goodman KW. Keynote presentation, Science National Honor Society Induction Ceremony, Miami-Dade Chapter, Barbara Goleman Senior High, Feb. 3.

Goodman KW. Ethical considerations in human subjects research. South Florida Human Subject Research Benchmarking Network, Hollywood, March 8.

Goodman KW. Ethics and evidence-based practice. "Conversations in Ethics," Baptist Health South Florida, South Miami Hospital, June 28.

Goodman KW, moderator, Miami-Dade County Commission District 8 candidates' debate, sponsored by the Urban Environment League, August 7.

Goodman KW, de Velasco R. Ethics and pandemic preparedness. Temple Judea Yom Kippur Seminar, Coral Gables, Oct. 2.

2005

Goodman KW. Enough already with the death and dying: New challenges in elder care. Keynote presentation, 15th Annual Board of Directors Installation & Awards Luncheon, Alliance for Aging, Inc., Miami, January 13.

Goodman KW. Bioethics: Foundations and fundamentals. Baptist Health System, Homestead Hospital, March 18.

Goodman KW. Panelist, What would I have done? The obligation to save a life. Miami Jewish Film Festival, March 20.

Goodman KW. Presenter, Exemplary Participation in the Science Symposium, MAST Academy, Miami-Dade County Public Schools, March 30.

Goodman KW. Ethical considerations in education. Barry University School of Nursing, "Nursing Education Leadership" class, April 5.

Goodman KW et al. "Patients in the crossfire: MDs v JDs and the malpractice reform fiasco. St. Luke Society of South Florida Annual Spring Bioethics Symposium at Holy Cross Hospital, Fort Lauderdale, May 5.

Goodman KW. Bioethics in a persistent legislative state. "Hot Issues in Healthcare," Palm Beach Medical Society, VA Medical Center and Legal Aid Society of Palm Beach County, West Palm Beach, May 6.

Goodman KW. Ethical and legal issues. Caregiver Workshop, UMSylvester Comprehensive Cancer Center and National Brain Tumor Foundation, Fort Lauderdale, June 4.

Callahan K, Goodman KW. Ethics and homelessness. Institute of Homeless Studies, Camillus House, Research, roles and resources: The Rx for ending chronic homelessness, Miami, September 26.

Goodman KW. When enough is enough: Making end-of-life decisions. Fawcett Memorial Hospital Medical Staff, Port Charlotte, Florida, October 6.

Goodman KW. Bioethics. Center for Humanism, Unitarian Universalist Congregation, South Miami, Nov. 30.

Goodman KW. Stem cell research and therapy: Political confusion, religious diversity and ethical principles. Brandeis University National Women's Committee, South Dade Chapter, Dec. 8.

2004

Goodman KW. Ethics: A secular perspective. Temple Kol Tikvah, Parkland, Fla., March 23.

Goodman KW, panelist. Getting Beyond Getting Along: Facing the Diversity of Miami-Dade's Ethical Traditions. UM Community Forum, Spring 2004 Series: Democracy in Miami: A Work in Progress, Coral Gables, Fla., April 14.

Goodman KW. Civic responsibility: The balance of ethics and quality of life. Greater Naples Chamber of Commerce leadership seminar. Naples, Fla., April 21.

Goodman KW. Business ethics and corporate governance in a post-Enron environment. Progress Club of Miami, July 14.

Goodman KW. Science and policy in Florida. MiamiIntelligence community forum, July 14, 2004.

Goodman KW. Moderator, Miami-Dade mayoral candidates ethics forum, League of Women Voters and Miami-Dade Commission on Ethics, Coral Gables, Aug. 12.

Goodman KW. Living well, dying well: Conversations and conflicts. Christ the King Lutheran Church, Pinecrest, Fla., Oct. 13.

Goodman KW. Ethics and guardianship. Broward County Guardianship Association, Pompano Beach, Oct. 20.

Goodman KW. Ethics and medical decision making. Broward County guardianship training program, Fort Lauderdale, Oct. 23.

2003

Member, Advisory Committee, Clergy End-of-Life Education Project, Hospice Foundation of America.

Reisner A, Goodman KW. Are we pushing the limits? Defining ethical boundaries of biotechnology research. Second Annual Wilstein Institute Forum at Beth David Congregation, Miami, Feb. 10 (Wilstein Institute of Jewish Policy Studies).

Goodman KW. Ethics, health and guardianship. Florida State Guardianship Association, Gulf Coast Chapter Winter Conference, Sarasota, Feb. 20.

Goodman KW. Ethical implications of HIPAA. Naples Community Healthcare System, Naples, Florida, Feb. 21.

Goodman KW. Data sharing and secrecy in science. Baptist Health South Florida, Third Annual IRB Educational Retreat, Duck Key, Fla., Sept. 20.

Goodman KW. Ethics and guardianship. South Florida Guardianship Association, Miami, Oct. 1.

Goodman KW. How to speak with your physician about end-of-life wishes. Indian River Memorial Hospital/Indian River County Main Library, Vero Beach, Fla., Oct. 17.

Goodman KW. Ethics in cancer care. Cascades Chapter, Papanicolaou Corps for Cancer Research, Boynton Beach, Oct. 22.

2002

Goodman K. Moderator, Symposium on stem cell research. With Prof. Mary Jo Iozzio, Barry University, Rabbi Joshua Kreindler, Jewish Federation of Broward County, Maulala Shafayat Mohamed, Darul Uloom Islamic Institute, Ani Karma Chotso, Kagyu Shedrup Choling Center. Temple Beth El, Hollywood, March 3.

Goodman K. Interviewee, South Florida Radio Broadcasters Association "ascertainment Interviews," June 19, 2002.

Goodman K. Session chair, Legal and Social Issues, Caring for the Elderly; sponsors: Jewish Federation of Broward County, Archdiocese of Miami, Holy Cross Hospital, Fort Lauderdale, Oct. 9.

Goodman K. Between the futile and the miraculous: Ethical, spiritual and social responses to new technology. South Florida Clergy Seminar, JMH Clinical Pastoral Education program, Oct. 23.

Iozzio MJ, Goodman KW. Stem cell research: The possibilities and perils. Tower Forum debate, Fort Lauderdale, Dec. 5.

2001

Goodman K. Religion and bioethics. South Florida Chaplains Association, Holy Cross Hospital, Fort Lauderdale, March 12.

Goodman K. Bioethics committees and end-of-life care. South Florida Guardianship Association, Miami, April 4.

Goodman K. Palliative and end-of-life care: Issues in respiratory therapy. Ninth Annual Harry Kapp Symposium, South Miami Hospital, Oct. 23.

Goodman K. NICU ethics: Challenges and solutions. South Miami Hospital NICU Update, Nov. 2.

2000

Goodman K. Medical ethics. Medical and Health Care Division, Greater Miami Jewish Federation, Miami, Jan. 12.

Goodman K. What is politics? And panel moderator, Business and politics in Miami-Dade. Greater Miami Chamber of Commerce, Leadership Miami program, Hialeah, March 4.

Goodman K. "Patient Rights," Post Polio Association of South Florida, Miami, April 16.

Goodman K. Business, Government and Professional Ethics, Concerned Matrimonial Lawyers of Dade County, Inc., Miami, Sept. 27.

Caralas P, Goodman K. Panelists, topics in health ethics, The Changing Face of America's Health Care, Miami Fellows Initiative, Dade Community Foundation, Oct. 27.

1999

Goodman, K., panelist, Facing the Challenge of Aging Parents: Legal, Moral and Social Issues. Temple Judea, Coral Gables, Fla., Jan. 12.

Goodman, K., keynote speaker, Alliance for Aging awards luncheon, "Real-World Good News: Bioethics in the Next Century," Miami, Jan. 21.

Goodman, K., Business Ethics in Health Care, Greater Miami Chamber of Commerce Health Industry Group, Miami, March 2.

Goodman, K, Medical Ethics, Adult Education Program, Temple Solel, April 16, Hollywood, Fla.,

Goodman, K. Banquet Address, Alpha Epsilon Delta, National Pre-Medical Honor Society, University of Miami chapter, Initiation Banquet, April 23.

Goodman, K. (et al.), Facilitator, "Choices When Values Collide," Palm Beach Area Agency on Aging, May 14, 1999, West Palm Beach, Fla.

Goodman K. Advance directives and living wills" Post Polio Association of South Florida, Sept. 18, Miami.

1998

Goodman, K. Difficult Cases for Ethics Committees, Doctors Hospital, Coral Gables, Fla., Jan. 17.

1997

Goodman K. Jewish Medical Ethics, Central Agency for Jewish Education, Fort Lauderdale, Feb. 26.

Goodman, K. Treatment Refusal by Incompetent Patients, South Florida Evaluation and Treatment Center, Miami, March 14.

Goodman, K. Ethics and Epidemiology, Florida International University Department of Public Health, Bioethics in Public Health course, April 9.

Panel moderator, When Enough is Enough: A Discussion on End of Life Issues, Health Council of South Florida, Miami, April 29.

Panelist, Medical Challenges to Religious Values, Meyer Baskin and Florence Baskin-Gordon Memorial Temple Judea/Technion Annual Lecture, Temple Judea, Coral Gables, Fla., May 7.

Goodman, K. Intensive Ethics Seminar, Florida Council of Operating Room Nurses, Aventura, Fla., July 19.

Panelist, "Religious and Ethical Perspectives on the Embargo, Cuban Health and Nutrition and the U.S. Embargo, Cuban Committee for Democracy and Olof Palme International Center, Miami, Sept. 13.

1996

Goodman, K. Rationing Health Care by Age. Huntington Lakes Condominium Association, Delray Beach, Florida, Feb. 9.

Goodman, K. "Role and Function of Ethics Committees," Epworth Village Retirement Community, April 10.

1995

Goodman K, Eisenstat MB. Gene therapy. Temple Judea, Coral Gables, Fla., Dec. 6, 1995.

Goodman, K. Panelist, Science, Technology and Humanity: Shaping a New Creation, Phi Theta Kappa national honor society, Broward Community College, Pembroke Pines, June 10, 1995.

Goodman, K. Patient Rights, Risk Management Seminar for Physicians, South Shore Hospital, Miami Beach, May 1, 1995

Goodman, K. Ethics at the End of Life, South Florida Association of Phi Beta Kappa, Miami, March 19, 1995.

Goodman, K. Progress in Ethics, Leadership Broward Health Day, Hollywood, Fla., March 10, 1995.

Goodman, K., Needell, M. Bioethics and Risk Management, Parkway General Medical Center Medical Staff, North Miami Beach, March 2, 1995.

Goodman, K. Ethics and Health Care Reform, Martin Memorial Medical Center, Stuart, Fla. "Ethics and Health Care Reform: A Workshop on Biomedical Ethics", May 4, 1994.

Goodman, K. Privacy, presented to Pittsburgh Professional Chapter of Women in Communications, March 19, 1991.

Goodman K, et al. Business & ethics. Greater Miami Chamber of Commerce, Miami, Jan. 20.

1994

Goodman K. Role of the ethics committee. North Broward Hospital District, "Update for Ethics Committees and Healthcare Workers," Fort Lauderdale, Nov. 5.

Goodman K. Coping with ethical dilemmas in health care reform, "Business Strategies for the Advanced Health Care Professional," Fort Lauderdale, Oct. 14.

Goodman K, panelist, Animal rights in education and research, "Human Values and the Environment," Dade Environmental Action Council, Miami, Oct. 22.

1993

Goodman K. Different cultures/different ethics? South Miami Hospital Cardiology Conference CME program, July 9.

31a. Other Community/Professional Service

1995-2016	Health Council of South Florida Ethics Committee
2009-2014	Member, Advisory Board, Victor Center for the Prevention of Jewish Genetic Diseases
2010	Member, Conflict of Interest Task Force, American Medical Informatics Association
2003-2010	Member, Board of Directors, Guardianship Program of Miami-Dade County
2004-2010	Chair, Academic Advisory Board, Youth Ethics Initiative
2005-2007	Member Florida PTA Child Protection Committee
2007-2008	Member, Miami-Dade County Commission on Ethics and Public Trust Ethics, Integrity and Accountability Task Force

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Doe v Ladapo: 4:23-cv-114

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

JANE DOE, individually and on behalf
of her minor daughter, SUSAN DOE;
BRENDA BOE, individually and on
behalf of her minor son BENNETT
BOE; CARLA COE, individually and
on behalf of her minor daughter
CHRISTINA COE; FIONA FOE,
individually and on behalf of her minor
daughter FREYA FOE; GLORIA GOE,
individually and on behalf of her minor
son GAVIN GOE; and LINDA LOE,
individually and on behalf of her minor
daughter LISA LOE; PATRICIA POE,
individually and on behalf of her minor
son PAUL POE,

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*;
FLORIDA BOARD OF MEDICINE;
SCOT ACKERMAN, NICHOLAS W.
ROMANELLO, WAEI BARSOUM,
MATTHEW R. BENSON, GREGORY
COFFMAN, AMY DERICK, DAVID
DIAMOND, PATRICK HUNTER,
LUZ MARINA PAGES, ELEONOR
PIMENTEL, HECTOR VILA,
MICHAEL WASYLIK, ZACHARIAH P.
ZACHARIAH, MARIA GARCIA,
NICOLE JUSTICE, *in their official
capacities as members of the Florida*

Board of Medicine; FLORIDA BOARD OF OSTEOPATHIC MEDICINE; WATSON DUCATEL, TIFFANY SIZEMORE DI PIETRO, GREGORY WILLIAMS, MONICA M. MORTENSEN, VALERIE JACKSON, CHRIS CREEGAN, WILLIAM D. KIRSH, in their official capacities as members of the Florida Board of Osteopathic Medicine; ASHLEY MOODY, in her official capacity as Attorney General for the State of Florida; GINGER BOWEN MADDEN, in her official capacity as State Attorney for the First Judicial Circuit of Florida; JACK CAMPBELL, in his official capacity as State Attorney for the Second Judicial Circuit of Florida; JOHN DURRETT, in his official capacity as State Attorney for the Third Judicial Circuit of Florida; MELISSA NELSON, in her official capacity as State Attorney for the Fourth Judicial Circuit of Florida; WILLIAM GLADSON, in his official capacity as State Attorney for the Fifth Judicial Circuit of Florida; BRUCE BARTLETT, in his official capacity as State Attorney for the Sixth Judicial Circuit of Florida; R.J. LARIZZA, in his official capacity as State Attorney for the Seventh Judicial Circuit of Florida; BRIAN S. KRAMER, in his official capacity as State Attorney for the Eighth Judicial Circuit of Florida; MONIQUE H. WORRELL, in her official capacity as State Attorney for the Ninth Judicial Circuit of Florida; BRIAN HAAS, in his official

capacity as State Attorney for the Tenth Judicial Circuit of Florida; KATHERINE FERNANDEZ RUNDLE, in her official capacity as State Attorney for the Eleventh Judicial Circuit of Florida; ED BRODSKY, in his official capacity as State Attorney for the Twelfth Judicial Circuit of Florida; SUSAN S. LOPEZ, in her official capacity as State Attorney for the Thirteenth Judicial Circuit of Florida; LARRY BASFORD, in his official capacity as State Attorney for the Fourteenth Judicial Circuit of Florida; DAVE ARONBERG, in his official capacity as State Attorney for the Fifteenth Judicial Circuit of Florida; DENNIS WARD, in his official capacity as State Attorney for the Sixteenth Judicial Circuit of Florida; HAROLD F. PRYOR, in his official capacity as State Attorney for the Seventeenth Judicial Circuit of Florida; PHIL ARCHER, in his official capacity as State Attorney for the Eighteenth Judicial Circuit of Florida; THOMAS BAKKEDAH, in his official capacity as State Attorney for the Nineteenth Judicial Circuit of Florida; and AMIRA D. FOX, in her official capacity as State Attorney for the Twentieth Judicial Circuit of Florida,

Defendants.

/

SECOND AMENDED COMPLAINT
FOR DECLARATORY AND INJUNCTIVE RELIEF

PRELIMINARY STATEMENT

1. This Action is a federal constitutional challenge brought by transgender adolescents and their parents against the bans on medical care for transgender minors adopted by the Florida Boards of Medicine and Osteopathic Medicine (“Medical Boards”) and by the Florida Legislature in Senate Bill 254 (“SB 254”), (collectively, the “transgender medical bans”). The bans adopted by the Medical Boards are effective as of March 16, 2023 (Board of Medicine, Rule 64B8-9.019, Fla. Admin. Code) and March 28, 2023 (Board of Osteopathic Medicine, Rule 64B15-14.014, Fla. Admin. Code). The ban created by SB 254 came into effect on May 17, 2023, when it was signed into law.

2. The transgender medical bans violate the rights of parents to make medical decisions to ensure the health and wellbeing of their adolescent children. They prohibit parents from seeking and obtaining effective medical treatment in Florida for their adolescent children by prohibiting doctors from providing medications to adolescents in accordance with the standards of care and clinical practice guidelines for treatment of a rare and serious medical condition, gender dysphoria.

3. The transgender medical bans also violate the guarantees of equal protection by banning essential medical treatments needed by the adolescent Plaintiffs because they are transgender.

4. Defendants cannot demonstrate any rational basis, much less an important or compelling one, for the transgender medical bans which prevent

transgender adolescents from obtaining safe and effective medically necessary healthcare.

5. The plaintiffs seek declaratory and injunctive relief to enjoin enforcement of the transgender medical bans. Without the relief sought, plaintiffs will suffer real and immediate injury.

PARTIES

I. Transgender Plaintiffs and Their Parents

6. Plaintiff Jane Doe is and has at all relevant times been a resident of St. Johns County, Florida. She is the mother of Plaintiff Susan Doe, an eleven-year-old transgender girl for whom she also appears in this case as next friend. Susan Doe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through her parent Jane Doe.

7. Plaintiff Brenda Boe is and has at all relevant times been a resident of Alachua County, Florida. She is the mother of Plaintiff Bennett Boe, a fourteen-year-old transgender boy for whom she also appears in this case as next friend. Bennett Boe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through his parent Brenda Boe.

8. Plaintiff Carla Coe is and has at all relevant times been a resident of Duval County, Florida. She is the mother of Plaintiff Christina Coe, a nine-year-old transgender girl for whom she also appears in this case as next friend. Christina Coe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through her parent

Carla Coe.

9. Plaintiff Fiona Foe is and has at all relevant times been a resident of Orange County, Florida. She is the mother of Plaintiff Freya Foe, a ten-year-old transgender girl for whom she also appears in this case as next friend. Freya Foe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through her parent Fiona Foe.

10. Plaintiff Gloria Goe is and has at all relevant times been a resident of Lee County, Florida. She is the mother of Gavin Goe, an eight-year-old transgender boy for whom she also appears in this case as next friend. Gavin Goe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through his parent Gloria Goe.

11. Plaintiff Linda Loe is and has at all relevant times been a resident of Miami-Dade County, Florida. She is the mother of Lisa Loe, an eleven-year-old transgender girl for whom she also appears in this case as next friend. Lisa Loe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through her parent Linda Loe.

12. Plaintiff Patricia Poe is and has at all relevant times been a resident of Miami-Dade County, Florida. She is the mother of Paul Poe, a nine-year-old transgender boy for whom she also appears in this case as next friend. Paul Poe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through his parent Patricia Poe.

II. Defendants

13. Defendant Joseph Ladapo, M.D., is sued in his official capacity as the

Surgeon General of the Florida Department of Health, which is responsible for “protect[ing] and promot[ing] the health” of all Floridians. Fla. Stat. § 20.43 (2022). The Surgeon General is appointed by the Governor and serves at the pleasure of the Governor. Fla. Stat. § 20.43(2) (2022). Defendant Ladapo, in his official capacity as Surgeon General of the Florida Department of Health, initiated the process of the promulgation of the transgender medical bans pursuant to the authority granted by Fla. Stat. § 20.43(g) (2022), regarding the regulation of health practitioners. Defendant Ladapo’s official place of business is located in Tallahassee, Leon County, Florida.

14. Defendant Scot Ackerman, M.D., is a member of the Florida Board of Medicine.

15. Defendant Nicholas W. Romanello, Esq., is a member of the Florida Board of Medicine.

16. Defendant Wael Barsoum, M.D., is a member of the Florida Board of Medicine.

17. Defendant Matthew R. Benson, M.D., is a member of the Florida Board of Medicine.

18. Defendant Gregory Coffman, M.D., is a member of the Florida Board of Medicine.

19. Defendant Amy Derick, M.D., is a member of the Florida Board of Medicine.

20. Defendant David Diamond, M.D., is a member of the Florida Board of

Medicine.

21. Defendant Patrick Hunter, M.D., is a member of the Florida Board of Medicine.

22. Defendant Luz Marina Pages, M.D., is a member of the Florida Board of Medicine.

23. Defendant Eleonor Pimentel, M.D., is a member of the Florida Board of Medicine.

24. Defendant Hector Vila M.D., is a member of the Florida Board of Medicine.

25. Defendant Michael Wasylik, M.D., is a member of the Florida Board of Medicine.

26. Defendant Zachariah P. Zachariah, M.D., is a member of the Florida Board of Medicine.

27. Defendant Maria Garcia, Esq., is a member of the Florida Board of Medicine.

28. Defendant Nicole Justice is a member of the Florida Board of Medicine.

29. Defendant Watson Ducatel, D.O., is a member of the Florida Board of Osteopathic Medicine.

30. Defendant Tiffany Sizemore Di Pietro, D.O., is a member of the Florida Board of Osteopathic Medicine.

31. Defendant Gregory Williams, D.O., is a member of the Florida Board of

Osteopathic Medicine.

32. Defendant Monica M. Mortensen, D.O., is a member of the Florida Board of Osteopathic Medicine.

33. Defendant Valerie Jackson is a member of the Florida Board of Osteopathic Medicine.

34. Defendant Chris Creegan is a member of the Florida Board of Osteopathic Medicine.

35. Defendant William D. Kirsh, D.O., is a member of the Florida Board of Osteopathic Medicine.

36. The Florida Board of Medicine is made up of fifteen members who are appointed by the Governor. Fla. Stat. § 458.307(1) (2022). Defendant members of the Florida Board of Medicine, in their official capacities, each separately and independently took actions to promulgate Fla. Admin. Code 64B-9.019 pursuant to their rulemaking authority under Fla. Stat. §§ 458.309 and 458.331(1)(v) (2022). Further, Defendant members of the Florida Board of Medicine, in their official capacities, each has the authority to enforce Fla. Admin. Code 64B-9.019, including taking disciplinary action against any doctor for violating its provisions. Fla. Stat. § 456.072. The Florida Board of Medicine is based and headquartered in, and the official place of business for the Defendant members of the Florida Board of Medicine is, Tallahassee, Leon County, Florida.

37. The Florida Board of Osteopathic Medicine is made up of seven members

who are appointed by the Governor. Fla. Stat. § 459.004(1) (2022). Defendant members of the Florida Board of Osteopathic Medicine, in their official capacities, each separately and independently took actions to promulgate Fla. Admin. Code 64B15-14.014 pursuant to their rulemaking authority under Fla. Stat.

§§ 459.005 and 459.015(1)(z) (2022). Further, Defendant members of the Florida Board of Osteopathic Medicine, in their official capacities, each has the authority to enforce Fla. Admin. Code 64B15-14.014, including taking disciplinary action against any doctor for violating its provisions. Fla. Stat. § 456.072. The Florida Board of Osteopathic Medicine is based and headquartered in, and the official place of business for the Defendant members of the Florida Board of Osteopathic Medicine is, Tallahassee, Leon County, Florida.

38. Defendant Ashley Moody is the Attorney General for the State of Florida. Defendant Moody, in her official capacity as Attorney General, is the “chief state legal officer.” Fla. Const. Art. IV, § 4(b). Pursuant to Fla. Stat. § 16.08, Defendant Moody exercises general superintendence and direction over the state attorneys as to the manner of discharging their respective duties.

39. Defendant Ginger Bowen Madden is the State Attorney for Florida’s First Judicial District.

40. Defendant Jack Campbell is the State Attorney for Florida’s Second Judicial District.

41. Defendant John Durrett is the State Attorney for Florida’s Third Judicial

CERTIFICATE OF SERVICE

I certify that I e-filed this appendix on ECF, which will email everyone requiring notice.

Dated: September 13, 2023

/s/ Mohammad O. Jazil