

No. 23-12155

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

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*August Dekker et al.,*  
Plaintiffs-Appellees,

v.

*Secretary, Florida Agency for Health Care Administration et al.,*  
Defendants-Appellants.

U.S. District Court for the Northern District of Florida, No. 4:22-cv-325  
(Hinkle, J.)

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**APPELLANTS' APPENDIX – VOLUME VII OF XXI**  
**PART 1 OF 2**

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Dated: October 13, 2023

/s/ Mohammad O. Jazil

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23. Donovan GK, Sheehan M. "Ethical Decision-making in the Elderly," Reichel's Care of the Elderly, 8<sup>th</sup> Edition, Cambridge University Press (IN PRESS – 2020)
24. Donovan GK, "CPR, DNR and the Patient's Good," Pellegrino's Clinical Compendium, (IN PRESS Catholic of University Press 2021)
25. Donovan, GK. "Ethical Issues in the Provision of Nutrition and Hydration," Pellegrino's Clinical Compendium, (IN PRESS Catholic University of America Press 2021)
26. Subramanian S, Donovan GK. "Chapter 101 Ethics in Prenatal/Neonatal Medicine," Handbook in Neonatology (IN PRESS India 2020)

**TEACHING:**

Health Care Ethics Required Course for First and Second Year Medical Students  
Georgetown University Medical School – Director 2012-2013, Co-Director 2014-2020

Introduction to Health Care Selective—Spring 2013  
Course Title: Medical, Ethics, and Spiritual Issues in End of Life Patient Care  
Co-teaching with Abigail Rian Evans, PhD, M.Div.

“Patients, Population and Policy” Course for Dept. of Family Medicine  
Georgetown University Medical Center  
Small group instructor Oct. 2012-February 2013

Contraception/Population and Demography Class, School of Nursing and Health Sciences (Faculty: Dr. Hazel Denton), November 8, 2013

Central Nervous System 1 Module, Georgetown School of Medicine, “Determining Brain Death”,  
January 14, 2014

Profession of Medicine Course for 1<sup>st</sup> and 2<sup>nd</sup> Year Medical Students, 2013, 2014, 2015, 2016, 2017, 2018  
2019

Mentoring Visiting Scholars in the Pellegrino Center for Clinical Bioethics 2013, 2014, 2015, 2016, 2017,  
2018

Mentoring 4<sup>th</sup> Year Medical Students in the Bioethics Clerkship, 2015, 2016, 2017, 2018, 2019

**(Updated MedStar Georgetown Hospital Teaching—3<sup>rd</sup> and 4<sup>th</sup> yr students, residents  
and fellows -- list can be supplied upon request)**

**ON GOING ACTIVITIES:**

Moderator Pediatric Ethics Rounds, MedStar Georgetown University Hospital  
Monthly beginning 2012 -2020

Clinical Service in Pediatric GI – procedures, attending and seeing patients beginning January 2013-2019

Ethics Consult Service provided by the Pellegrino Center for Clinical Bioethics for MedStar Georgetown University Hospital beginning September 2012-2020

MGUH Ethics Committee

Student Humanities in Medicine Interest Group, Georgetown University Med School, 2012-2013

Moral Distress Conferences for nurses in MedStar Georgetown University Hospital

End-of-Life conferences with nurses in MedStar Georgetown University Hospital

Faculty advisor to:

Medical Students for Life  
Gold Humanism Honor Society  
Student Catholic Medical Association

2<sup>nd</sup> Opinion Clinic for Pediatric Gastroenterology and Nutrition, MedStar GU Hospital -2019

Transplant listing meetings

**COMMITTEE ASSIGNMENTS AND BOARDS - GUMC**

ACA – Affordable Care Act review committee – for GUMC 2012-13

Member Ethics Committee for MedStar Georgetown University Hospital 2012-present

Bioethics and Christian Theology Affinity Group, GU 2012-2013

Gold Humanism Committee, GU Med School 2012-2013,2014-2020

ERD Discussions GUMC 2012-2013

On-going discussions with Allen Roberts, MD and Thomas Fishbein, MD re uterine transplantation

**Search Committee** for MedStar Georgetown University Hospital Chaplain 2012-2013

Georgetown School of Medicine **Committee on Students** 2013-2019

Board of Advisors for Mission and Ministry 2013 -

Subcommittee , Transplant Ethics Committee 2013

Ruesch Center for the Cure of GI Cancers, Board of Advisors 2013-2019

Committee to Develop a Curriculum in Reflection, Formation, and Leadership  
2024-present

LIFE MOOC, Advisory Board 2014-present

End of Life Committee 2014 - present

Service and Social Justice Working Group GUMC 2015-

Curricular Content Committee – 2016-2018

Global Health Initiative – 2017-

Ad Hoc Committee – MedStar/PCCB re PAS – 2017

LCME 2019 Co-Chair Self Study Committee 2017-2018

**SERVICE OUTSIDE OF GEORGETOWN UNIVERSITY MEDICAL SCHOOL**



**MEDCAC – Medical Evidence Development and Advisory Committee, Center for Medicare and Medicare Services 2017**

**ASBH Clinical Ethics Consultation Affairs (CECA) Committee (one year term) Oct. 2017-2018**

**Center for Bioethics and Human Dignity Advisory Committee, , Deerfield, IL 2017-2021**

MedStar system Ethics Committee 2018-2020

GUMC-MedStar Committee on Research Development 2018-

MedStar Committee Launching PGx 2018-

**Uniform Law Commission:** Study Committee on Disposition of Human Embryos and Gametes at Divorce, Separation and Death, – 2019 –

**NIH Human Fetal Tissue Research Ethics Advisory Board 2019**

**SEARCH COMMITTEE, Kennedy Institute of Ethics, Director 2019-2020**

**OTHER ACTIVITIES/ASSIGNMENTS**

Review of manuscript for the Kennedy Institute of Ethics Journal on “The Affordable Care Act and Community Benefit: A Mandate Catholic Health Care can Embrace” submitted November 13, 2012

Named Editor-in-Chief **Philosophy, Ethics and Humanities in Medicine** – web journal 2016-2018

Grant on Advanced Directives, writer with Allen Roberts, MD, Medstar Georgetown University Hospital 2013 ( *not awarded*)

Participated in Meeting of Jesuit Center Leadership Feb. 24, 25, 26, 2013

Host Committee – Med Students for Life Speaking Tour 2013

Interview for Magnet Site Visit Oct. 15, 16, 17, 2013

Participate in MNE (Metabolism, Neurology, Endocrine) Middlesex discussion panel, September 30, 2013, Georgetown University Medical Center

Grant written to Scholl Foundation for \$50,000 for fellowships – 2014

Professionalism Panel at First Year Orientation GU Med School, Aug. 8, 2014, 2015, 2016, 2017, 2019

**AWARDS AND COMMENDATIONS:**

“*G. Kevin Donovan Award in Bioethics*” –named in 2012 in recognition of Dr. Donovan’s contributions during his two decades of leadership of the Oklahoma Bioethics Center

Most-Cited Articles as of September 1, 2013 (MIND quarterly review of philosophy)  
G. Kevin Donovan, “Decisions at the End of Life: Catholic Tradition”  
Christian Bioethics (1997) 3 (3) 188-203 doi: 10.1093/cb/3.3.188

Best Doctors in America/Washington Post Magazine 2013

Best Doctors in America—named in 2013-2014

Nominated for:

Golden Apple Award – (teaching) Georgetown University Medical School - 2014

American’s Best Physicians, 2016

Best Doctors in America 2017-2018



**EXHIBIT "A"**

Florida Medicaid Project: Treatment for Transgender Children

Medical Experimentation without Informed Consent:

An Ethicist's View of Transgender Treatment for Children

G. Kevin Donovan, MD, MA  
5-12-2022

## **Florida Medicaid Project: Treatment for Transgender Children**

### **Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children**

#### **I. The Issue**

Growing controversy attends the diagnosis and treatment of individuals identifying as transgender, particularly those who are still children or adolescents. As was recently pointed out, leading medical, mental health, and public health organizations support understanding gender-diverse youth and providing gender-affirming medical (hormonal) and other(surgical) care as the standard of care, including the American Academy of Pediatrics, American Psychological Association, Centers for Disease Control and Prevention, Society for Adolescent Health and Medicine, and the American Medical Association. Major nursing organizations—the American Nurses Association and the American Academy of Nursing— have made statements that young people's access to inclusive, safe, and competent health care is a human rights issue. (Wolfe, I., & Goepferd, A. "Child Abuse in Texas." *The Hastings Center*. 14 Mar. 2022) However, this widespread support is not going unchallenged, even by those who have been providing medical interventions for these children and adolescents.

Recently, questions have arisen about the appropriateness of both the diagnosis, and the safety and efficacy of these interventions that have been strongly encouraged up until now. Currently, less than half of state Medicaid programs provide gender affirming care. (Mallory, C., & Tentindo, W. "Medicaid coverage of gender-affirming care." Williams Institute, UCLA School of Law. Oct 2019). The Florida Surgeon General has said that minors should not undergo gender transition procedures, puberty blockers and hormone treatments. "[Florida Department of Health Releases Guidance on Treatment of Gender Dysphoria for Children and Adolescents](#)." 20220420-Gender-Dysphoria-Press-Release | Florida Department of Health.) In Texas, the state attorney general issued a decision that gender-affirming medical treatments such as puberty-suppressing hormones fall under the definition of child abuse in Texas state law. In fact, 34 states have introduced legislation to limit hormonal and surgical interventions for such transgender patients. This aligns with similar reassessments and limitations in the United Kingdom, Sweden, Finland, and France. A new position statement from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) stresses the importance of a mental health evaluation for people with gender dysphoria — in particular for children and adolescents — before any firm decisions are made on whether to prescribe hormonal treatments to transition or to perform surgeries, often referred to as "gender-affirming care." "There is a paucity of quality evidence on the outcomes of those presenting with gender dysphoria. In particular, there is a need for better evidence in relation to outcomes for children and young people," the guidance states.

Given the legitimate concerns about the diagnosis, treatment, and the paucity of supportive, scientific studies in regard to the interventions being offered to minors who identify as transgender, I will offer a view of these from the perspective of an ethicist and pediatrician. This will be done in the face of strong and sometimes heated opposition to any variance from the currently prevailing recommendations. Each category of currently recommended or potential treatments will be briefly considered within this framework. The evidence base for these will be reviewed, and an overall argument made that such interventions must be considered as medical experimentation, subject to the requirements of research in childhood with informed consent. Finally, I will conclude with an examination of the fundamental flaw of the transgender project in childhood, and how it is leading to inevitable and controversial challenges.

In order to do this, we must review the ethical requirements for medical research in childhood and the elements of **informed consent**. Because of numerous abuses in the past, a strong system of regulations and oversight has been developed for the protection of human subjects in the United States. This began with the Belmont Report: (<https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html>) The report not only described the ethical principles listed below, but led to guidelines for research protections that are now codified in Federal regulations (Code of Federal Regulations, or ‘CFR’) and monitored by the U.S. Department of Health and Human Services (DHHS). These led to the establishment of IRBs (Institutional Review Boards) which are responsible for the protection of human subjects in federally funded research—IRBs are the Federally mandated committees that review research activities for the protection of human subjects. The Office for Human Research Protections (OHRP) provides leadership in the protection of the rights, welfare, and wellbeing of subjects involved in research conducted or supported by the DHHS. The OHRP helps ensure this by providing clarification and guidance, developing educational programs and materials, maintaining regulatory oversight, and providing advice on ethical and regulatory issues in biomedical and social-behavioral research. These measures have laid the ground rules for human research, in adults and children including the need for informed consent.

Although adults may be included in research, this should only be done with *fully informed consent*, and the requirements will differ for children and other vulnerable subjects. The bedrock of these protections lies in obtaining the informed consent from the participant. Informed consent to medical treatment and research involvement is fundamental to both ethics and law. The process requires that a *fully autonomous patient* have the ability to *understand relevant medical information* about the proposed interventions, including the *risks, benefits if any, and alternatives* (including doing nothing/non-participation), and consent *voluntarily* without *coercion*. This is rooted in respect for the **ethical principles of autonomy, beneficence, and justice**.

**Autonomy** is derived from respect for persons, which requires that we not only respect those who are fully autonomous but protect those individuals that are not fully autonomous. Vulnerable subjects such as children cannot legally or ethically participate in the consent process due to their age and maturity level. The rules for their involvement are set out by the Code of Federal Regulations (46 CFR 401-409). While consent cannot be given for another person, parents or guardians can give “permission” and children can give assent to the extent that they are able. The process of obtaining assent should be appropriate to the age, maturity, and psychological development of the child. The consent process must contain three ethically required components: *information, comprehension, and voluntariness*. Deficiencies in any of these categories would invalidate the process. The main contention here is that deficiencies in *all* these categories can be found in the current approach to minors who identify as transgender, and current attempts at treatment should not proceed as they are now practiced.

**Beneficence** is reflected in the complementary expressions of (1) do no harm and (2) maximize possible benefits and minimize possible harms. An assessment of risks and benefits will depend heavily on the delivery of accurate and complete information as described above. An assessment of risk will include both the probability and the severity of envisioned harms, both physical and psychological.

Finally, **justice** requires fairness in distribution of risks and benefits. It suggests that not only should like cases be treated alike, but different approaches are appropriate for different circumstances. This is highly relevant in the selection process for those being subjected to the various interventions while still minors.

Thus the process of informed consent must proceed with a correct diagnosis, the nature and purpose of recommended interventions, the known burdens and benefits of all options, including doing nothing or forgoing the intervention. While not able to do an exhaustive review of these elements as they apply to the main treatment approaches recommended for transgender minors, we can briefly examine each category to assess for obvious deficiencies. The issue of deficient information will be significant in each category, and questions of comprehension and voluntariness will be addressed at the end.

## II. The Interventions

### Surgery

A variety of surgeries have been performed on transgender adults. These range from removal of both breasts (bilateral mastectomy) and associated chest reconstruction, nipple repositioning, dermal implant and tattooing, to gender surgery for trans men which includes construction of a penis (phalloplasty or metoidioplasty), construction of a scrotum (scrotoplasty) and testicular implants, or a penile implant. Removal of the womb (hysterectomy) and the ovaries and fallopian tubes (salpingo-oophorectomy) may also be considered. Surgery for trans women includes removal of the testes (orchidectomy), removal of the penis (penectomy), construction of a vagina (vaginoplasty), construction of a vulva (vulvoplasty), construction of a clitoris (clitoroplasty), as well as breast implants for trans women, facial feminisation surgery and hair transplants. Certainly there are multiple known risks to this long list of surgeries. These used to be described as “sex-change” operations: they are now termed “gender affirming surgeries.” The semantic shift is important, as we will see.

Most, but not all, practitioners would delay undertaking these permanent alterations in minor children and adolescents. This may be as much for legal reasons as for medical considerations. However, the lack of sexual maturity in younger patients, especially if previously delayed by puberty blocking agents, makes the sparse tissue more difficult to work with and outcomes less favorable, with problems such as wound rupture more likely. These are not challenges that are routinely described to minors at the beginning of their treatment progression with puberty blocking agents or hormones. This deficit of information would be a major failing.

### Hormonal Treatment

Treatment with cross-sex hormones is a mainstay of gender affirming care. These result in the changes in body habitus, facies, voice tone, and hair development that transgender patients seek. They are described as “gender affirming”, “life-saving” and “a human right” by their proponents. They have been prescribed by Planned Parenthood clinics and others after a first visit for gender dysphoria (<https://www.plannedparenthood.org/planned-parenthood-greater-texas/patient-resources/transgender-healthcare>). Surely no one would argue that such a precipitous practice has been accompanied by a full psychological evaluation, or disclosure of medical risks. Chief among these is the fact that the resulting bodily changes will not disappear, even if the initial desire for them changes. And this change is no unlikely development – upwards of 80% of minors who identify as transgender will reverse this identity by the time they reach their mid-20’s if left untreated, and revert to their previous identification, albeit possibly with a same-sex attraction. It is more than simply changes in one’s body that are at risk; sex hormones have an important and lasting effect on brain development and adolescent psychology. To not fully appreciate this fact, or to not have it delineated in the first place, is an egregious failure of informed consent.



## Puberty Blockers

Perhaps the greatest failure of informed consent, and non-disclosure of human experimentation outcomes, is found in the supposedly benign use of puberty blocking agents in minors. They are routinely and widely prescribed with the thought that this will “buy time” for those questioning their gender as minors. Children and their supportive parents are assured that they are a benign intervention whose effects are easily reversible, just in case the child decides not to transition. Some potential effect on the development of bone density may be mentioned. The extent of this danger is just now being appreciated, with severe and disabling osteoporosis described in at least one child in Sweden. This led to new guidelines for gender-affirming care issued in February by the National Board of Health and Welfare. It stated that, based on current knowledge: “the risks of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh the possible benefits, and that the treatments should be offered only in exceptional cases.” However, the effect of puberty blocking agents (started in early adolescent development) on long-term sexual function seems to be largely unstudied. Current guidelines recommend starting puberty blockers at the earliest stage of sexual maturation in children (Tanner two). These will not only prevent the enlargement of penile tissue, it will desensitize the orgasmic potential for tissues later exposed to cross-sex hormones. Simply put, transgender adults treated in early adolescence with puberty blockers may never experience orgasm. When children with gender dysphoria are given these powerful hormones (around age 11) they are too young to appreciate the implications of what will happen.

It is not simply a matter of chronology. As children mature into adolescents and adults, their brains are also being formed and reformed under the influence of sex hormones. There is evidence for structural changes, and these are likely to be demonstrated in cognitive and behavioral changes. In fact, the development of the adolescent brain and the maturation of its rational and executive functions does not typically complete until one’s early 20s. Although the deleterious effects on sexual development and function in adulthood from puberty blockers may be predicted, no one is entirely certain of the effects on other critical areas such as brain development and bone density. Carefully constructed and monitored studies have not been done. *Until they are, these off-label treatments with puberty blockers and cross sex hormones can only be considered experimental.* Experimental interventions should be done as carefully as any other research, and fully informed consent is the only ethical way to enter into such studies. Clearly, this is not the current practice.

### III. The Fundamental Flaw

There appears to have been a headlong rush in the past decade towards the process of gender affirming care described above. After close scrutiny, it can only be seen as off label experimentation, despite the fact that informed consent practices do not conform to this reality. Given this, we must ask ourselves: how can experienced and ethical physicians so mislead others or be so misled themselves? In 2013, the American Psychiatric Association published their update of the Diagnostic and Statistical Manual of Mental Disorders, the DSM-5. In it the diagnosis of “gender identity disorder” was replaced with “gender dysphoria.” This was done to “avoid stigma and ensure clinical care for individuals who see and feel themselves to be a different gender” other than the one to which they were born. The APA stated that “it is important to note the gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition.” Dysphoria is a state of uneasiness, unhappiness, or dissatisfaction. With this change in terminology there was also a shift from seeking or correcting the underlying cause of the dysphoria, and a focus on transitioning to the preferred gender.

This revision has probably done more harm than good by accepting a self-diagnosis characterized by the belief that the patient (or their essence) is “trapped in the wrong body.” This concept relies on the Cartesian duality, a body-self dichotomy. It reverts to the fallacious “ghost in the machine” concept. In reality, we cannot be trapped in the wrong body; we are our bodies, which are an integral and inseparable part of ourselves. To assert that there is a female self inside a male body (or the reverse), is to fail to achieve a full understanding that we are embodied persons, unified body and mind, if you will. A generation ago, sex and gender were taken to be synonyms for the same phenomena. Even now, a transgender female, no matter how much or how long of a hormonal therapeutic regimen they undergo, is still genetically male. Ignoring this fact has led to a contradiction, where sympathetic practitioners recommend “holistic care” while insisting on a fragmented concept of the self. This approach has been warmly embraced, even insisted upon, by many practitioners while viewed as nonsensical and even ludicrous by many laypersons.

Inevitably this has led to added difficulties. Even young patients are encouraged to begin puberty blockers and then hormones based on a self-diagnosis. Self-diagnosing psychiatric conditions is always fraught with the possibility of error. In this case, there can be no confirmatory lab tests, radiologic exams, or genetic findings. Moreover, the dysphoria can only be diagnosed and opened to treatment if it is causing significant trauma to the individual. The clinically significant distress manifests itself in underlying psychiatric diagnoses such as depression and suicidality. It is argued that embarking on affirmative treatment as early as possible is urgently needed to prevent further psychiatric complications, a contested assertion. Studies have shown that adult transgender persons continue to have evidence of depression and suicidality following treatment. The rate of suicide among post-operative transgender adults in a study from Sweden found an incidence 20 times greater than that of the general population. Such treatment may not be urgently needed to protect adolescents; it may not even be effective protection for their adult counterparts.

The claim of urgency coupled with an impulse toward nonjudgmental empathy for the disturbed patients has led to a frantic insistence on a single approach that may seem almost cult like in its insularity and opposition to outside challenges. Both parents (Trinko, K. (Nov. 19, 2018 “What It’s Like to Lose Your Children to the ‘Transgender Cult,’ From a Mom Who Knows.” *The Daily Signal*, 30 Oct. 2019) and teachers (Manning, M. for The Mail on Sunday, “Whistleblower Teacher Makes Shocking Claim That ‘Most Are Autistic.’” *Daily Mail Online*, Associated Newspapers, 19 Nov. 2018, <https://www.dailymail.co.uk/news/article-6401593/Whistleblower-teacher-makes-shocking-claim-autistic.html>.) report that their children or students are being wrongly encouraged at school to think of themselves as transgender. Sometimes this is the result of overenthusiastic acceptance or “love bombing”. Sometimes it appears to influence the susceptible, as in autistic children. Sometimes transgender counseling is taking place even without the parents’ knowledge, and this troubling approach has been supported in the literature with statements that adolescents should be legally empowered to obtain puberty-blocking without parental consent (Priest, M. Transgender Children and the Right to Transition: Medical Ethics When Parents Mean Well but Cause Harm. *Am J Bioeth.* 2019 Feb;19(2):45-59).

Inevitably, this has resulted in complications and conflicts. The media have been replete with reports of such things as contested accessibility of transgender females to such things as domestic abuse shelters, female prisons, and female sports competitions. Similar issues regarding bathroom accessibility in schools recently came to a boil in Virginia, when it came to light that a sexual assault by a self-described trans- female (with a penis) was repeated in another school after the perpetrator was transferred. (Poff, J. “Loudoun superintendent failed to inform state of school sexual assault.” *Washington Examiner*, 4 May 2022.) These issues are far from any resolution by debate, discussion, or legislation. In fact, both sides of the debate have doubled down with insistence that the opposing viewpoint must not only be rejected but considered unethical and made illegal.

Some disturbing trends have developed resulting not only from this dichotomy of opinion about the proper treatment approach, but ultimately based in the acceptance of the mind-body dichotomy. There has been a change in the diagnosed population. As Abigail Schrier pointed out:

For the nearly 100-year diagnostic history of gender dysphoria, it overwhelmingly afflicted boys and men, and it began in early childhood (ages two to four). According to the DSM-V, the latest edition of the historical rate of incidence was 0.01 percent of males (roughly one in 10,000).

For decades, psychologists treated it with “watchful waiting” — that is, a method of psychotherapy that seeks to understand the source of a child’s gender dysphoria, lessen its intensity, and ultimately help a child grow more comfortable in her own body. Now such an approach is disdained by the term “conversion therapy”, and labelled as unethical, and even made illegal.

She continues:

Since nearly seven in 10 children initially diagnosed with gender dysphoria eventually outgrew it, the conventional wisdom held that, with a little patience, most kids would come to accept their bodies. The underlying assumption was children didn’t always know best. But in the last decade, watchful waiting has been supplanted by “affirmative care,” which assumes children do know what’s best. Affirmative care proponents urge doctors to corroborate their patients’ belief that they are trapped in the wrong body. The family is pressured to help the child transition to a new gender identity — sometimes having been told by doctors or activists that, if they don’t, their child may eventually commit suicide. From there, pressures build on parents to begin concrete medical steps to help children on their path to transitioning to the “right” body. That includes puberty blockers as a preliminary step. Typically, cross-sex hormones follow and then, if desired, gender surgery. (Shrier, A. “Top Trans Doctors Blow the Whistle on ‘Sloppy’ Care.” Emmaus Road Ministries, 5 Oct. 2021)

These pressures apply not only to parents, but to the children themselves because of the strong emphasis on affirmative support for anyone declaring themselves transgender. As one mother described: “A lot of these kids have concurrent mental health issues, and they find a place to fit in because as soon as you say that you’re trans, you get love-bombed,” she reflects. “You get love-bombed online, you get love-bombed on at school ... As soon as you say you’re trans, you turn into a star. And kids are thirsty for that kind of affirmation.” (Trinko, 2019)

Two phenomena may be associated with this. Strong affirmation for the diagnosis and hormonal treatment may be altering the natural course of the phenomenon in childhood. It may not only be easier to identify as transgender in today’s environment; it may be more difficult to turn ones back on the diagnosis. This may help explain a recent report that found that an average of 5 years after their initial social transition, 7.3% of youth had retransitioned (changed gender identity) at least once. At the end of this period, most youth identified as binary transgender youth (94%), including 1.3% who retransitioned to another identity before returning to their binary transgender identity. 2.5% of youth identified as cisgender and 3.5% as nonbinary. Later cisgender identities were more common amongst youth whose initial social transition occurred before age 6 years; the retransition often occurred before age 10. Unlike previous studies of transgender youth, males were not predominant, but were outnumbered by 2 to 1. Moreover, this is a direct contradiction of previous data showing a high rate of reversion towards a sex/gender coherence in children as they mature. (Olson, Kristina R., Durwood, Lily, Horton, Rachel, Gallagher, Natalie M., & Devor, Aaron; Gender Identity 5 Years

After Social Transition. *Pediatrics* 2022; 10.1542/peds.2021-056082) We must ask if this represents a shift towards being trapped in a wrong diagnosis, rather than a child being trapped in a wrong body.

In fact, there has been another shift. Unlike in the past, we now see increased numbers of females identifying as transgender, and later in their adolescence. Sometimes this occurs in large cohorts within a single school or peer group, a phenomenon labelled “rapid onset gender dysphoria.” Both these phenomena call into question the underlying cause for the concept of gender dysphoria. Rather than approaching it as an accurate self-diagnosis that must be affirmed and treated to change the outward sexual appearance, isn’t there a better model? We may be making a fundamental mistake in approaching transgender phenomena, not as a disease or disorder, but at most a dysphoria that is a cause for affirmation. This contrasts with our approach to similar conditions claiming a mind-body divergence, such as anorexia nervosa or body integrity identity disorder. The former is familiar to most Americans. The latter is a rare mental disorder characterized by a desire to have a physical disability, claiming discomfort with being able-bodied and often resulting in a request for amputation of the body part that makes them uncomfortable. People with this condition may refer to themselves as “trans abled.”

In all three of these conditions there is a claim for a mismatch between one’s mental bodily image and physical body. All tend to find an onset in prepubescence and are frequently associated with other mental disturbances. “Affirmative care” is the only recommended standard for transgender patients. It is horribly disturbing to contemplate amputation of a healthy limb because of a mental disorder (although this has been done). No one would seriously consider surgery to limit caloric intake or weight gain for a patient with anorexia nervosa, in order to support and affirm her distorted body image. Nevertheless, sex change operations have been recast as “gender affirming surgeries”. The change in language reflects the change in attitude that distorts the approach to treatment for a psychiatric, not medical/surgical, disorder.

Finally, what are we to make of this situation, as a medical profession, and as a society? This question cannot be answered until both the affected people and profession can overcome our collective hubris. It is not enough to admit we don’t know all the answers. We must see that we are not yet certain of all the questions that must be answered. In such a situation, competing interests must not pretend to take the moral high ground when no one can be certain where it will be located. First and foremost, we must back off from our current approaches until questions can be answered with proper studies, done with sufficient patients, and sufficient controls, over a sufficient period of time. Any insistence on a single course of therapy without this information could prove to be the same type of morally unacceptable interventions that caused formal research protections to be created in the first place.

In the meantime, we must adopt a more respectful tone with those whom we disagree. As John Milton said, “Where there is much desire to learn, there of necessity will be much arguing, much writing, many opinions; for opinion in good men is but knowledge in the making.” Most important of all, in order to protect the current and future well-being of these affected children, we must rely on the ancient principal of medical ethics “In the first place, do no harm.” Until we can demonstrate the efficacy and safety of any proposed treatment or intervention, its usage must properly be considered a medical experimentation and require fully informed consent. Anything less is a betrayal of both our principles and our progeny.

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*About the author: Dr. Donovan’s observations flow from his professional experience. He has been a Board-certified pediatrician for over 40 years, as an academic physician who rose to Vice-chair of the Department of Pediatrics and ultimately interim Chair at the University of Oklahoma in Tulsa. His professional role and interests expanded in the 1990’s after he took a sabbatical in medical ethics at*

*Georgetown University under the world-famous Dr. Edmund Pellegrino, a founding father of modern bioethics. He subsequently went on to earn a master's degree in Bioethics and founded the first bioethics center in his home university, where he was responsible for ethics training and education for students and physicians. He also served as clinical ethics consultant for three teaching hospitals. He was chair of the Section on Bioethics for the American Academy of Pediatrics (AAP) for three years and then their first liaison member of the AAP Committee on Bioethics. He has also served as the chair for a hospital Institutional Review Board for 17 years. Finally, he was asked to become Director for the Center for Clinical Bioethics at Georgetown University School of Medicine, where he served from 2012-2020. His duties included teaching, consultation, publishing papers and speaking on bioethics extensively at the local, national, and international level on four continents. He has been interviewed and quoted on National Broadcasting Company (NBC), National Public Radio (NPR), Eternal Word Television Network (EWTN), and Al Jazeera, as well as the New York Times and the Washington Post, among others. He was awarded the Humanism in Medicine award from the Gold Foundation, which recognizes physicians to have successfully integrated humanism into the delivery of care to their patients and families. He has also offered formal testimony on bioethical issues before state legislatures and the U.S. Congress.*

## Appendix Attachment

10

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF FLORIDA  
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.,

Plaintiffs,

v.

Case No. 4:22-cv-00325-RH-MAF

SIMONE MARSTILLER, et al.,

Defendants.

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**DECLARATION OF JOSEPH ZANGA, M.D.**

I, Joseph Zanga, M.D., 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. While my curriculum vitae (attached) outlines my background and expertise, I here provide a few details as amplification.
3. After graduating from college with a major in Biology and a minor in Philosophy and Theology (Ethics), I matriculated to Medical School where I quickly determined that my career path would be to care for children in the context of their families.
4. After Medical School my Internship and Residency led me to an academic career beginning with a further year of education as a Fellow in Community Pediatrics. Though active in the direct care of children in the context of their families, my work in academic centers teaching premedical (college), medical, nursing and other students, pediatric and family medicine residents, as well as post-graduate physicians and others, made me a lifelong student of medicine in all its varied iterations. This is how I came to work with adolescents, work in and direct programs in Child

Abuse/Child Protective Services, build a Community Coalition to end human trafficking, and in all of these areas studied the physical, mental, and emotional development of children to young adulthood.

5. I continue, even in retirement, to do so, serving for a time as Health and Safety Chair for a 3 county Boys and Girls Club and as a member of my County Community Resilience Collaborative, among other activities where my education and experience might be useful.

6. I have been retained by the Defendants in the case to describe my experience with the American Academy of Pediatrics (AAP), to express my opinion regarding the AAP's decision-making process for positions taken by the AAP regarding gender dysphoria treatments, and to express my opinions about current, non-science-based approaches, to gender dysphoria in children and adolescents. If called to testify in this matter, I would testify truthfully based on my almost 50 years of pediatric study about, experience with, and knowledge of, the health and being of children and adolescents.

7. I am being compensated at an hourly rate of \$400 per hour for my time preparing this declaration. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

8. I have been a Fellow of the AAP for about 50 years having joined because of their role as a defender of the health and well-being of children. I joined because of the high regard in which it was held by my professors and colleagues. I joined to receive quality continuing education and become involved in the work it was doing on behalf of children. Over the years I've encouraged many pediatricians, and pediatricians-in-training to join. While still an AAP Fellow, and participant in AAP activities, I have become concerned about its direction in recent years.

9. During these 50 years the AAP has grown from 30,000 or so members to about 67,000 members. (Please note that **Fellows** are Board Certified Pediatricians while **members** include students, Residents, pediatric dentists, and others working with children. Members also include



pediatricians and others in Canada, Mexico, and other nations. There are more Board Certified Pediatricians in the USA than Fellows of the AAP. So the 67,000 members aren't all the US pediatricians.

10. The AAP has also grown from a small office in Evanston, to a new, quite large, building in Itasca, and a smaller office in Washington, DC, with a combined staff compliment in the hundreds. Member dues are the bedrock of support but there is increasing funding from government, foundations, and the pharmaceutical industry.

11. Distressing to me and other members is a bent towards what was termed "political correctness" in issues such as gender dysphoria.

12. When an issue of concern impacting children is brought to its attention, the AAP considers the development of Policy to address it. The process usually begins with the Board of Directors (BOD) which refers the issue to a standing Committee (usually), Council, or Section Executive Committee to develop a Statement for publication. Committees have 10 to 15 members, the majority of whom are Fellows chosen by the BOD from AAP Chapter recommendations. There are also non-Fellow members who may or may not be Pediatricians. When completed, the Statement is referred back to the BOD for discussion, perhaps review by other relevant Committees, etc. for their opinion, and then a BOD vote. If a majority approves, the Policy is published as a product of the AAP, referencing the Committee, etc. and the principal author.

13. The process is therefore internal and involves none of the other AAP Fellows/Members who are not Committee, etc. members. The voting Board is composed of 17 members with one elected by Fellows in each of the 10 AAP geographic Districts. There are 3 at-large members elected nationally and a 5 member Executive Committee, 4 elected nationally, and the employed CEO. There is no review or vote by the remainder of the AAP membership.

14. From the above (#12 & #13) AAP Policy cannot be said to reflect opinions/beliefs of all, or even a large cross-section of, even AAP members. There is one potential exception to this and that is the Annual Leadership Forum (ALF). Occurring in the late Summer to early Autumn of each year, the ALF brings together Chapter officers, Committee (etc. Chairs, the BOD, and others to review Resolutions, submitted by AAP Fellows, Chapters, etc., requesting that the AAP take action on an issue. The Resolutions, if approved, are only advisory to the BOD but do call BOD attention to issues.

15. With respect to the Gender Dysphoria issue, Resolutions were submitted to the ALF in 2021 and 2022. In 2021, Resolution 33 asked the AAP to study further the science of this children's issue currently presented as AAP policy. It was written with abundant referenced science and an extensive bibliography. In the Reference Committee (B) to which this resolution was assigned, it received 50 yes votes, 12 no votes, and perhaps 10 abstentions. At 80.65% it had about the highest support of any resolution in Reference B, yet the Committee "Had No Recommendation" (neither for nor against it being presented to the entire ALF) and the resolution then disappeared, never apparently brought to the main voting session. A similar resolution in 2022, simply again asking the AAP to study the issue, was rejected on procedural grounds and never presented at the ALF.

16. Many wonder why this potential objection to the AAP position of transgender affirmation was treated so unscientifically and undemocratically. This is quite opposite my past experience with the AAP and the ALF (then called the ACF), as in the past there was always vigorous discussion of controversial issues. For the proposal on this issue, at least in 2021, there seemed to be little controversy. The Reference Committee members overwhelmingly wanted it presented to the ALF.

17. So why is the AAP so set in their defense of children/adolescents being allowed to begin transitioning at almost any age. Is this in the best interest of children? The simple answer is “no”.

18. My first written statement on the issue, after much research, *First Do No Harm* (attached), was published in my local medical society newsletter in July of 2018 and was updated and republished in the Spring 2020 AAP Senior Bulletin. What was written then is still true today. In outline form here are the continuing/expanded reasons for my concern:

- a) As I noted in #4 & #8 above, Pediatricians, guided by the AAP, have always provided care for children in the context of their families. Why is the AAP now not discouraging, or perhaps even encouraging, schools and others working with children to keep parents uninformed about transitioning ideation and actions?
- b) From the start of my pediatric education, I was taught that parents are the decisions makers for their children as children/adolescents are too immature and inexperienced to make potentially life altering decisions.
- c) In the 1990s, science verified what was long ago known and taught to pediatric trainees in the 1960s – 1980s, that the brains of children are incapable of making long term, life changing, decisions until their early to mid-20s.
- d) The AAP as always held firmly to this position from its origins as an organization. We expected that it would do so even more with science documenting the rightness of this approach.
- e) For the most part the AAP does teach that children need parental, and often pediatrician, guidance in important matters. We also articulate many “thou shalt nots” directly to youth. We tell them that they should not drink (alcohol), use tobacco products or other drugs, to avoid tanning beds, not operate or ride with

another on an ATV, and refrain from excessive media use, among other activities. We make clear that if a child, usually an adolescent, comes to us seeking diet advice or medication for a perceived body image problem (anorexia) our approach is to seek out the underlying problem and counsel, or refer for counseling, to correct the unreasonable thinking and “cure” the child. We do not “affirm” their body image problem and assist them in losing weight. We do not provide diet pills or weigh loss surgical procedures. There are other things we would not recommend no matter the request of the child or parents (growth hormone to improve sports performance, weight loss to wrestle in a lower weight category, are among these).

- f) It is at least puzzling then that we do precisely that when a youth, incapable of making such a decision, requests to transition to the opposite sex. This is especially concerning when good studies have shown that the desire to do this disappears in most (80 – 90%) after passing through puberty or by late adolescence.
- g) As this is our standard for care for almost all other issues it is distressing to me that the AAP recommends that we affirm a child’s desire to transition, provide help to do so, and works to prohibit counseling to cure the desire at its root even to the extent of supporting the legal punishing of counselors who might provide that service. This despite knowing that appropriate counseling can work to dissipate gender dysphoria
- h) In addition, the AAP seems to ignore the potential harms which might accrue, some of which may be impossible to know at present. We do know however:
  - i. That puberty-delaying or gender-affirming hormone therapy, diminishes bone mineral density, at least in the short term.

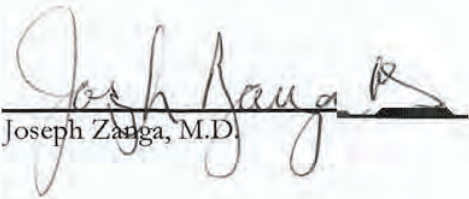
- ii. That many of the drugs used increase blood pressure, risk of obesity, cardiac disease, blood clots, strokes, diabetes, and cancers. They also have deleteriously effects on the (presently immature and malleable) brain. Unfortunately, for none of these do we have long term studies, though short term studies and projections from adult are not favorable. It is inappropriate medical care to experiment on youth in this fashion, waiting for years or decades to learn if we were right or wrong.
- iii. That even the easily observable immediate ill effects seem to be irreversible.
- iv. That the basic premise is scientifically impossible and dangerous. We are born with every cell of our body unmistakably male or female. That cannot be changed by drug or surgical manipulation, so no boy can ever be a girl or girl be a boy. Since we know that males and females respond to medications differently and present with illnesses in different ways (a heart attack, or Type 1 Diabetes where girls are more likely to have higher A1C levels than boys when first diagnosed and continued to have higher levels after treatment begins. Girls also need higher basal insulin and total insulin doses than boys, for instance), imitating the opposite sex can lead to improper treatment or a missed diagnosis
- v. That increasing numbers of those who have transitioned are attempting to retransition.
- vi. That rates of suicide are twenty times greater among adults who've used cross-sex hormones and/or have undergone sex reassignment surgery, even in Sweden which is among the most transgender

affirming countries.

- vi: That several “developed” nations, including the United Kingdom, Sweden, Finland, and France have all taken steps to pull back on transgender medical treatments for seemingly gender-dysphoric children.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 27<sup>th</sup> day of September, 2022.

Respectfully submitted,

  
Joseph Zanga, M.D.

## CURRICULUM VITAE

- 1 Joseph Robert Zanga, MD, FAAP
- 2 Chief of Pediatrics – Columbus Regional Health (Retired - July 2015)
- 3 President, 1997–1998, American Academy of Pediatrics
- 4 President, 2002 - 2007, American College of Pediatricians

### 1. PERSONAL INFORMATION:

- 1.1 Business Address: 2031 Long Point Trail  
Sanford, NC 27332  
919 343 2003
- 1.2 Married to: Christine E. Zanga (1969)  
Children: Catherine A. Zanga, JD (Deceased 2014)  
Joseph R. Zanga, Jr., MD

### 2. LICENSURE:

- 2.1 Licensed in the State of Georgia #062014 (Inactive)
- 2.2 Licensed in the State of North Carolina #2003–00108
- 2.3 Licensed in the State of Illinois #036–101427 (Inactive)
- 2.4 Licensed in the State of Louisiana #12064R (Inactive)
- 2.5 Licensed in the Commonwealth of Virginia #2282 (Inactive)
- 2.6 Licensed in the State of New York #119949 (Inactive)
- 2.7 Diplomat of the National Board of Medical Examiners
- 2.8 American Board of Pediatrics, Certification #20986
- 2.9 Pediatric Advanced Life Support (PALS) Provider and  
Instructor Credentialed, 1989, Re-credentialed, 1992, 1995

### 3. EDUCATION:

- 3.1 Loyola University – Stritch School of Medicine, MD degree conferred June 1971
- 3.2 Fordham University – New York City B.S. Biology awarded June 1966

### 4. POSTDOCTORAL TRAINING:

- 4.1 Certificate in Health Care Management, Loyola University Chicago, June 20, 2001
- 4.2 MCH/APA National Faculty Scholars Development Program, 1999–2001
- 4.3 Ambulatory Pediatric Fellowship, 1974–75, Robert Haggerty, MD, Chair, and Evan Charney, MD, Program Director, at Strong Memorial Hospital of the University of Rochester, Rochester, New York
- 4.4 Chief Residency in Pediatrics, 1973–74, William Laopus, MD, Chair, at the Medical College of Virginia, Richmond, Virginia (Now VCU School of Medicine)
- 4.5 Pediatric Residency, 1972–73, William Laopus, MD, Chair, at the Medical College of Virginia, Richmond, Virginia (Now VCU School of Medicine)
- 4.6 Pediatric Internship, 1971–72, David Yi–Yung Hsia, MD, Chair, at the Loyola University Medical Center, Maywood, Illinois

### 5. PAST ACADEMIC APPOINTMENTS:

- 5 Chief of Pediatrics – Columbus Regional Health (Retired - July 2015)  
6 Clinical Professor of Pediatrics – Medical College of Georgia  
7 Clinical Professor of Pediatrics – Philadelphia College of Osteopathic Medicine  
Clinical Professor of Pediatrics – Mercer University School of Medicine
- 5.1 Assistant Dean for Primary Care and Director, Office of Generalist Programs, East Carolina Brody School Of Medicine, Max and Catherine Joyner Endowed Professor in Primary Care, 2003(January)– Retired 2009 (December)
- 5.2 Chair, Department of Pediatrics, M. C. Clark Endowed Professor of Pediatrics, Loyola University, Stritch School of Medicine, 2000(January) –2002(December)
- 5.3 Vice Chair, Department of Pediatrics, Louisiana State University Medical Center 1997(January)–1999(December)
- 5.4 Professor of Pediatrics and Emergency Medicine with Tenure, LSUMC (Associate Appointment, Tulane Medical School) 1997–1999
- 5.5 Professor of Pediatrics and Emergency Medicine with Tenure, Virginia Commonwealth University/Medical College of Virginia, 1996
- 5.6 Professor of Pediatrics with Tenure, Medical College of Virginia, 1987–1996
- 5.7 Chair, Division General Pediatrics and Emergency Care, Medical College of Virginia, 1987–1996
- 5.8 Director, Virginia Injury Prevention Center, Medical College of Virginia, 1987–1996
- 5.9 Director, Developmental/Behavioral Fellowship, Medical College of Virginia, 1986–1993
- 5.10 Director, Community Pediatric Fellowship, Medical College of Virginia, 1979–1993
- 5.11 Associate Professor of Pediatrics, Medical College of Virginia, 1978–1987 (Tenure granted 1981)
- 5.12 Director, Section of Ambulatory and Emergency Care, Department of Pediatrics, Children's Medical Center, Medical College of Virginia, 1978–1987
- 5.13 Project Director, Health Underserved Rural Areas Program, Department of Pediatrics, University of Virginia Medical Center, 1976–1978
- 5.14 Assistant Professor of Pediatrics, University of Virginia, 1975–1978
- 5.15 Project Director, Children and Youth Project, Department of Pediatrics, University of Virginia Medical Center, 1975–1978
- 5.16 Coordinator, Ambulatory Pediatric Fellowship Program, University of Virginia School of Medicine, 1975–1978
- 5.17 Instructor in Pediatrics, University of Rochester, 1974–1975
6. MEMBERSHIPS:
- 6.1 Georgia Chapter of the American Academy of Pediatrics, 2009 - 2019  
Board of Directors – Permanent Adviser  
Fall CME Program Committee, 2009 – 2019  
Chair – 2011, 2014



- Honorary President (Elected by the Board) June 2016 – June 2017
- Georgia Pediatric Health Improvement Coalition Board, 2011 – 2017
  - Co-Chair IT/Telemedicine Committee, 2012 - 2017
- 6.2 Medical Association of Georgia, 2009 – Present (Life Member)
  - Task Force on Health Insurance and Medicare (2018)
  - Muscogee County Medical Society
    - Executive Committee and Chair Program Committee, 2010 - 2013
    - Elected Delegate to Medical Association of Georgia, 2011 – 2019
- 6.3 Georgia Alliance of Community Hospitals 2010 - 2014
- 6.4 American College of Pediatricians (Board of Director – 2002 – 2014)
  - Member Founding Board (2002)
  - President 2002–2007 (Re Elected 2005)
- 6.5 North Carolina Pediatric Society/NC Chapter of the American Academy of Pediatrics, 2003–2010, 2019-Present
- 6.6 American Medical Association, 1995-Present
  - Section on Medical Schools – BSOM elected faculty representative, 2004-2009
    - At-Large member, 2009 - 2011
  - Region 4 (Southeast) Medical Student Section – Elected Faculty Advisor, 2008 - 2010
- 6.7 North Carolina Medical Society, 2003–2010, 2019 - Present
  - Pitt County Medical Society Delegate, 2004-2009
  - Family and Public Health Committee, 2005-2009
- 6.8 Medical Institute for Sexual Health, Board of Directors, 2001–2005
  - Advisory Board – 2019 - Present
- 6.9 Ambulatory Pediatric Association, 1978–2013
- 6.10 American Academy of Pediatrics (Life Fellow)
  - Past Presidents' Advisory Committee (Founding Chair), 1998 - Present
  - Chair, Committee on Board Compensation 2000–2001
  - Chair, Executive Committee, Section on Bioethics, 1999–2003,
  - Section on Bioethics Nominating Committee, 2003–2005
  - President 1997–1998**
  - Vice President/President Elect 1996–1997
  - Board of Directors, 1989–1998
  - Advisory Committees to the Board on Membership and 5 others, 1989 - 1995
    - Chair, Advisory Committee on Research, 1992
    - Chair, Advisory Committee on Membership, 1993
    - Chair, Advisory Committee on Development, 1994
  - Advisory Committee to the Board on Strategic Planning, 1992–1994, 1997–1998
  - Chair, District IV (Southeast), 1989–1995
  - Alternate District Chair, District IV, 1988–1989
  - Chair, Founding Chair, Section on School Health, 1987–1989
  - Council on Sections, 1987–1989
  - Committee on School Health, 1981–1987; Chair, 1983–1987
  - Council on Child and Adolescent Health, 1983–1987

Sections on: Bioethics, School Health

- 6.11 Virginia Pediatric Society/Virginia Chapter of the American Academy of Pediatrics  
Honorary Life Member – Voted 1997  
Chair, Council on Child and Adolescent Health 1988–1990  
Chapter President – 1985–1988  
Chapter Vice President – 1982–1985, Secretary–Treasurer: 1979–1982

7. AWARDS/HONORS:

- 7.0 *Master of the College* - American College of Pediatricians – October, 2017
- 7.1 Honorary President (2016 – 2017) – Georgia Chapter AAP – June 10, 2016
- 7.2 The Outstanding Clerkship Director – Mercer University School of  
Medicine Class  
of 2016, March 18, 2016
- 7.3 Columbus Regional Health Physician Recognition Award 2015 – Nominee for  
Physician of the Year in Teaching
- 7.4 Certificate of Appreciation – Columbus State University Competitive Premedical  
Studies Program. March 19, 2015
- 7.5 The Outstanding Pediatric Faculty Award – Mercer University School of Medicine Class of  
2014, May 1, 2014 and Mercer Class of 2015, March 20, 2015
- 7.6 Excellence in Medical Education Award – Georgia Campus - Philadelphia College of  
Osteopathic Medicine, April 9, 2010
- 7.7 Outstanding Contribution Award (Teaching) – Georgia Campus - Philadelphia  
College of Osteopathic Medicine, 2009, 2010/2011
- 7.8 Elected to Rotary International, Rotary Club of Columbus (GA), 2009
- 7.9 New Student Organization of the Year Award, ECU Student Leadership Awards Banquet,  
April 27, 2008, for the Rural Health Care Volunteer Society (Faculty Adviser)
- 7.10 Guest of Honor and Keynote Speaker, Alpha Epsilon Delta Pre-Health Honor Society,  
Induction Ceremony, April 19, 2008
- 7.11 Keynote Speaker, The Schweitzer Fellows Celebration of Service (Induction Luncheon),  
2007 and 2008
- 7.12 Dedication Award (Highest Honor), BSOM M2 Class, April 10, 2008
- 7.13 Best Doctors in America 2000-2012, North Carolina Top Doctors (Pediatrician) 2021
- 7.14 AMA Physician's Recognition Award with Commendations in CME. 2004 – 2008.
- 7.15 National Health Services Corps "Spirit of the Corps" Award presented at the 2007  
Ambassador's Conference: Training to Serve, July 27-28, 2007, Memphis, Tennessee.
- 7.16 Guide to America's Top Pediatricians, 2004 – 2008, 2014 Editions.  
Consumers' Research Council of America.
- 7.17 Title of Professor of Honour, Senate of the University of Medicine and Pharmacy of  
Targu Mures, Romania, September 12, 2005
- 7.18 Business North Carolina Magazine, Top Doctors, 2004, 2005
- 7.19 Award in Recognition – Brody (ECU) Rural Health Interest Group, April 7, 2003

- 7.20 Who's Who Among America's Teachers, 2002. 7th Edition
- 7.21 Visiting Professor, University of Hawaii Post Graduate Program at Chubu Hospital, Okinawa, Japan, January, 2002
- 7.22 Visiting Professor, University of Medicine and Pharmacy, Targu Mures, Romania Diploma of Honour, Awarded May 18, 2001
- 7.23 American Academy of Pediatrics, Section on School Health, Milton J.E. Senn Award, October, 2000
- 7.24 National Center for Missing and Exploited Children, Rainbow Award, February 27, 1999
- 7.25 APA National Pediatric Faculty Development Scholar Awards, 1999–2001
- 7.26 Community Service Award, School of Medicine, VCU/MCV, May 18, 1996
- 7.27 Virginia Governors School, Commonwealth of Virginia, Certificate of Commendation, August 4, 1995
- 7.28 Alpha Omega Alpha – Epsilon Chapter, 1991
- 7.29 Distinguished Service Award, Virginia Commonwealth University, 1988
- 7.30 Award for “Excellence in Medicine and Community Service,” National Italian–American Foundation, October 11, 1987
- 7.31 Award in Appreciation – Human Growth Foundation, October, 1986
- 7.32 Annual Award for Outstanding Service to the Brain Injured, MCV–VCU, Williamsburg, VA, June, 1985
- 7.33 American Academy of Pediatrics, Outstanding Service Citation, 1985
- 7.34 American Academy of Family Practice Teaching Recognition Certificate, 1980
- 7.35 Outstanding Pediatric Resident Award, 1973–74, Medical College of Virginia
- 7.36 Senior Award for Scholastic Excellence, June, 1971, Stritch School of Medicine

## 8. COMMITTEES - Columbus Regional Health

- 8.1 Columbus Regional Medical Group AOC, 2014 - 2015
- 8.2 Family Advisory Council (Founding Chair), 2013 - 2015
- 8.3 Continuing Medical Education Committee, 2009 – 2015
- 8.4 Pediatric Executive Committee, 2009 – 2015
- 8.5 Pediatric Strategic Planning Committee, 2009 – 2015
- 8.6 Family Medicine Internal Review Committee, 2011- 2015  
Chair – Transitional Year Internal Review Committee, 2012

## 9. COMMITTEES – ECU/BRODY/PCMH:

- 9.1 Academic Affairs, 2002–2007

- 9.2 Faculty Sponsor, Rural Health Interest Group, 2002–2008
  - 9.3 Faculty Sponsor, American Medical Student Association, 2002–2009
  - 9.4 Brody Council Committee, 2003-2008
  - 9.5 M1, M2, M3, M4 Curriculum Committees, 2003–2008
  - 9.6 Executive Curriculum Committee, 2003–2008
  - 9.7 MD/7 Advisory Committee, 2004–2008
  - 9.8 Chair, Family Medicine Chair Search Committee, 2004–2005
  - 9.9 Delegate to Section on Medical Schools, AMA, Elected by BSOM Faculty, 2004–2009
  - 9.10 Medical Ethics Committee, University Health Systems of Eastern North Carolina, PCMH, 2006–2008
    - 9.10.1 Chair, Pediatrics Ethics Consultation Subcommittee, 2008
  - 9.11 Board of Governor’s Distinguished Professor for Teaching Awards Review Committee, 2007–2008
  - 9.12 Promoting Healthful Eating to Prevent Weight Gain in Young Adults Advisory Board, 2007–2008
  - 9.13 Search Committee for the Associate Vice Chancellor for International Affairs, 2008
10. COMMITTEES – LUMC:
- 10.1 Ronald McDonald Children’s Hospital Committee of the Board, 1999; Chair, 2000–2002
  - 10.2 Ronald McDonald House Board, 2000–2002
  - 10.3 Medical Center Ethics Committee, 2000–2002
  - 10.4 Medical Executive Committee, 1999–2002
  - 10.5 Clinical Leadership Committee, 1999–2002
  - 10.6 Marfan Syndrome Program Committee, Chair, 2000–2002
  - 10.7 Committee on Academic Rank and Tenure, 2001–2002
11. COMMITTEES – MCV/VCU:
- 11.1 University Council, 1993–1996
  - 11.2 Executive Committee, Virginia Center for the Advancement of Generalist Medicine (RWJ Generalist Grant), 1992–1996
  - 11.3 Medical Director, Child Protection Committee, 1980–1992; Member, 1992–1996
  - 11.4 University Tenure and Promotion Appeals Committee, 1990–1993
12. COMMITTEES – COMMUNITY:
- 12 Boys & Girls Clubs - Central Carolina – Board & Chair Safety Comm – 2020- 2022
  - 12.1 Sanford, NC *Resilience Committee* – 7/2019 - Present
  - 12.2 Sanford, NC, Crime Prevention and Youth Committee, 2019

- 12.2 Columbus Court Appointed Special Advocate (CASA) for Children, 2016 – 2019
- 12.3 Columbus Rotary *End Human Trafficking Now Coalition* 2015 - 2019  
Chair - November 2016 - 2019
- 12.4 Right from the Start – Building Strong Marriages and Families, Pastoral Institute,  
2015 -2017
- 12.5 Columbus State University Leadership Council, 2015 - 2019  
College of Letters and Science – Strategic Planning Committee, 2017 - 2018
- 12.6 Columbus State University Competitive Pre-Med Advisory Group, 2015- 2019  
Community Director (Founder) Primary Care Shadowing Program
- 12.7 Project Launch Committee, Georgia State and Local Health Dept, 2015 - 2019
- 12.8 Columbus Symphony Orchestra Board, 2015- 2019  
Finance Committee – 2017 – 2019
- 12.9 Columbus Child Fatality Review Team, 2012 - 2013
- 12.10 Live Healthy Columbus/Strong 4 Life Obesity Project Convener. Founding Chair.  
Elected Chair, May 2011. Reelected, May 2012, Executive Committee 2013 – 2018
- 12.11 Georgia Pediatric Health Improvement Coalition Board (PHIC), Co-Chair  
IT/Telemedicine Committee 2011 - 2017
- 12.12 Georgia Children’s Health Alliance – Executive Committee – Appointed by Lt.  
Governor Casey Cagle, 2010 - 2011
- 12.13 Family and Public Health Committee, North Carolina Medical Society, 2006–2009.
- 12.14 Member of the Board, Medical Institute, Austin, Texas, 2001-2006
- 12.15 Academic Advisory Board, Pfizer Scholars Grants for Faculty Development  
in Pediatric Health, 2000–2003
- 12.16 Chicago Rotary (Rotary One), Advisory Group on International Pediatric Health  
Services, 2000-2002
- 12.17 Reviewer, Center for Pediatric Emergency Medicine,  
National Child Protection Education Project, 2000–2003
- 12.18 Board of Directors, Vice President, Commonwealth Care of Virginia, Inc., 1995–1996
- 12.19 Board of Directors and Executive Committee, St. Joseph's Villa, 1993–1996  
Chair–Medical Advisory Committee, 1995–1996
- 12.20 Managed Care (Medallion) Medicaid Advisory Board,  
State Department Medical Assistance Services, 1992–1996
- 12.21 Virginia Bar Association Commission on the Needs of Children,  
Founding Member, 1986–1992
- 12.22 State Emergency Medical Services Advisory Council,  
Appointed by Governor Robb, 1982–1986  
Reappointed by Governor Baliles, 1986–1988

### 13. ADMINISTRATIVE EXPERIENCE:

- 13.1 Pediatric Clerkship Program Director, Mercer University School of Medicine, Columbus Campus, 2014 - 2015
- 13.2 Chief of Pediatrics, Columbus Regional Healthcare System, 2009 – 2015 (Retired)
- 13.3 Adjunct Professor in the Office of Interdisciplinary Health Sciences Education, Division of Health Sciences, Brody SOM, 2004–2008.
- 13.4 Director, Office of Generalist Programs, Brody SOM, 2002–2008
- 13.5 Faculty Mentor for Junior Faculty BSOM from: Pediatrics, IM, FM, 2003–2008
- 13.6 Medical Director, Ronald McDonald Children’s Hospital, 1999–2002
- 13.7 Chair, Ambulatory Pediatric Division, LSUMC, and Director Pediatric Emergency Medicine at Charity Hospital for LSU and Tulane, New Orleans, LA, 1997–1999
- 13.8 Chair, Division of General Pediatrics and Emergency Care, Medical College of Virginia, 1987–1996
- 13.9 Director, Section of Ambulatory and Emergency Care, Children’s Medical Center, Medical College of Virginia, 1978–1987
- 13.10 Medical Director – PruCare (MCO) of Richmond, 1987–1990
  - Chair, Physicians Advisory Committee
  - Chair, Quality Assurance Committee
  - Chair, Utilization Management Committee
  - Member, Executive Committee
  - Member, Pharmacy and Therapeutics Committee
- 13.11 Medical Coordinator, Richmond Juvenile Detention Home, 1986–1996

### 14. CONSULTANCIES:

- 14.1 Medical Advisory Board for the DiscoveryHealth.com Disease and Conditions Encyclopedia, DiscoveryHospital.com and HealthTeacher.com, 2007– 2009
- 14.2 National Advisory Child Health and Human Development Council, NIH/NICHHD, 2006–2011
- 14.3 Chair, Lysosomal Storage Disorders (LSD) Education Initiative, 2004–2006
  - Chair, LSD Pediatric Education Development Project, 2004
- 14.4 National Advisory Council of the National Center for Primary Care, David Satcher, MD, PhD, Director, 2003–2010 (reappointed 3 times)
- 14.5 Johnson & Johnson Consumer Products Co. Pediatric Advisory Board, 2002–2005
- 14.6 Human Growth Foundation Medical Advisory Council, June, 1986–1991

### 15. BIBLIOGRAPHY:

#### **15.1 Articles**

- Zanga, J.R. “First Do No Harm” AAP Section on Seniors Bulletin. Spring 2020 Vol 29 (2); 20-21
- Zanga, J. R. “First Do No Harm” Muscogee County Medical Society *Bulletin* June 2018

Vol. 63 (4); 18-19

Zanga, J. R. "The Medical Home" Muscogee County Medical Society *Bulletin* April 2014

Vol.59 (4);14-15

Zanga, J. R. "The 'Affordable' Care Act (ACA)" Muscogee County Medical Society *Bulletin*

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June, P.L., Trumbull, D.A., Zanga, J.R. "Regarding 'The Partial Death of Abortion Rights'  
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May/June 2007

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Collier DN, Zanga JR. Teaching residents and students to help patients and their families with obesity. *Virtual Mentor*. October 2006. 8:663-666. Available at:

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- Ogren, J.M. and Zanga, J.R.: "Sexual Abuse: Incidence, Complications, Evaluation and Therapy." *Virginia Medical*, 110:488, 1983
- Zanga, J.R.: "What is the Risk of a Second Child Having Seizures?" "Is There Any Medication to Prevent Convulsions?" "Is Surgery Needed for an Umbilical Hernia?." in *500 Questions New Parents Ask*, Dell, New York, 1982
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- Zanga, J.R.: "Immunizations: A Critical Problem in Preventive Health Care." *Virginia Medical*, 105: 436, 1978
- Cunningham, D. and Zanga, J. R.: "Myiasis of the External Auditory Meatus." *J. Peds.*, 84:857, 1974
- 15.2 Letters**
- Zanga, J.R.: "Shots Are Not Abusive," *Peds* 60:384,1977
- Zanga, J.R.: "Alternatives to the Intermountain Regional Poison Control Center," *Veterinary and Human Toxicology*, 22:394,1980
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- Zanga, J.R.: "Removing Financial Barriers to Pediatric Care," *The New England Journal of Medicine*, 339:1,1998
- Zanga, J.R.: "Sexual Abuse and Adolescent Pregnancy," *JAMA*, 281:6,1999
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McConnell M., et al, Zanga J.R.: "The Effects of Marriage, Civil Union, and Domestic Partnership Laws on the Health and Well-being of Children," *Pediatrics*, November 2006, Vol. 118(5): p 2259

**15.3 American Academy of Pediatrics Publications:**

Zanga, J.R.: "Ethics Code Inconsistent Concerning Executions and Abortions." (Letter), *AMNews*, 2/28/05

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Zanga, J.R., et al: AAP Committee on School Health: "School-Based Health Clinics." *AAP News*, May, 1987

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Zanga, J.R., et al: AAP Committee on School Health: "Qualification and Utilization of Nursing Personnel Delivering Health Services in Schools." *Pediatrics*, 79:647–648, 1987

Zanga, J.R. (Chair): Committee on School Health, AAP: "School Health: A Guide For Health Professionals." 2<sup>nd</sup> Edition, 1987

Zanga, J.R., et al: AAP Committee on School Health: "CPR Training in the School." *AAP News*, February, 1986

Zanga, J.R., et al: AAP Committee on School Health: "School Health Examinations." *AAP News*, February, 1986

Zanga, J.R., et al: AAP Committee on School Health and Burrell, P.A., et al: AAP Committee on Infectious Disease: "School Attendance of Children and Adolescents with HTLV III/LAV Infection." *Pediatrics*, 77:430–432, 1986

Zanga, J.R., et al: AAP Committee on School Health: "Concepts of School Health Programs." *AAP News*, December, 1985

Zanga, J.R., et al: AAP Committee on School Health: "Home Instruction." *AAP News*, December, 1985

Zanga, J.R., et al: AAP Committee on School Health: "School Bus Safety." *AAP News*, February, 1985

Zanga, J.R., et al: AAP Committee on School Health: "Education to Strengthen the Family." *AAP News*, January, 1985

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Zanga, J.R., et al: AAP School Health Committee: "Guidelines for Urgent Care in School." *Pediatrics*, 74:148, 1984

Zanga, J.R., et al: AAP School Health Committee: "Heat Stress and School Closings." *Pediatrics*, 74:313,1984

Zanga, J.R., et al: AAP Committee on School Health: "Alcohol Abuse Education in School." *AAP News*

Zanga, J.R., et al: AAP Committee on School Health: "Administration of Medication in School." *Pediatrics* 74:433, 1984

#### **15.4 Books, Chapters, Monographs:**

Zanga, J.R. Disorders of Temperature: Hyper-and Hypothermia in: *Pediatric Hospital Medicine*, 2<sup>nd</sup> Edition, 2008. Perkin, R., Swift, J, Newton, D, and Anas, N. (eds Lippincott, Philadelphia), 2008, P101-104

Fitch, J.T., McIlhaney, J., Adam, M. Hagar, MD, and Zanga, J.R. (Contributors): "Sex, Condoms and STDs: What We Now Know." The Medical Institute for Sexual Health, 2002

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Zanga, J.R. (ed): *Emergencies Pediatrics*. Interlivros Edicoes Ltda; Rio de Janeiro, 1988, Portuguese edition

Zanga, J.R. (ed): *Manual of Pediatric Emergencies*. Churchill Livingstone, Inc., New York, 1987 (Authored five chapters)

Spencer, C., Walker, D., and Zanga, J.R.: "School and the Handicapped Child." *Pediatric Clinics of North America*, October, 1986, p. 1251-1264

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#### **15.5 Abstracts:**

Bissonnette-Pitre, L., et al (...Zanga, J.R.). To Protect and Prevent: The Sexual Abuse of Children and its Prevention. The Catholic Medical Association, 2006.

Zanga, J.R.: "Mobile Health Care: Bringing Medical Care Home." The 23rd International Congress of Pediatrics, September 10, 2001

Gautier, K.B., Peck, G.Q., Ferrand, C., Collier, E.A., Sgritto, J., Kaye R.E., Zanga, J.R.: "Aerobic/Cross Training Program Improves Baseline Asthma and Fitness in Children."

*Southern Society for Pediatric Research*, 1997

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Sanders, J.K. and Zanga, J.R.: "Child and Adolescent Drownings in Virginia: A Population Based Study." APHA Annual Meeting, November 1, 1994

Sanders, J.K. and Zanga, J.R.: "Injuries to Children: A Statewide System for Injury Surveillance in the Pediatric Office Setting." Second World Conference on Injury Control, Atlanta, GA., May 23, 1993

Sanders, J.K. and Zanga, J.R.: "Playground Safety Workshop." Second World Conference on Injury Control, Atlanta, GA, May 20, 1993

Sanders, J.K., Waring, E., and Zanga, J.R.: "Finding The Missing Data – A Statewide System For Injury Surveillance in The Pediatric Office." *American Journal of Diseases of Children*, 145: 416, 1991

Zanga, J.R.: "The Short Statured Child." Assoc. for the Care of Children's Health, Cleveland, Ohio, June 12–15, 1988

Henderson, E.L., Zanga, J.R., et al. "Physician Bias and The Interpretation of Rapid Tests For Group A Streptococcal Pharyngitis." *Am Jour Diseases of Children*, 142:405–406, 1988.

#### **15.6 Posters and Media:**

Zanga, J.R. Champions for Children. Muscogee County Medical Society Bulletin, 55, 6, May, 2010

Forrow, L., O'Donnell, J., Irons, T., Zanga, J.R.: "Ideas in Action: The Schweitzer Fellows Program." Poster Presentation at AAMC, November 7-9, 2004

Zanga, J.R. (Work Group Chair): "Identifying Lysosomal Storage Disorders in Pediatric Practice – The Importance of Early Diagnosis." Speaker Slide Kit, Genzyme, Inc. 2004

Sy, B. and Zanga, J.R.: "Subarachnoid Hemorrhage Secondary to Bleeding Carotid Aneurysm." NC Pediatric Society Resident Poster Session, August 17-20, 2006

Cuellar, J.G., Zanga, J.R.: "Hearts-N-Parks: Salud para su Corazon." NHMA, Washington, DC, 2006

Kaplan SA, Merritt KB, Zanga JR, et al: "Healthy Smile, Healthy Child: A Pilot Study." North Carolina Pediatric Society, August 17-19, 2007

Fischer H, Zargham S, and Zanga JR: "Effects of Media Education on Children's Perceptions of Health Issues." BSOM/ECU Summer Scholars Research Day, August 18, 2008

Fischer H, Zargham S, and Zanga JR: "Effects of Media Education on Children's Perceptions of Health Issues." AMA Medical Student Section Research Poster Session, AMA Interim Meeting, Orlando, Florida, November 8, 2008

#### **15.7**

Journal Reviewer, 2014 - Present. *Linacre Quarterly*

Journal Reviewer, 2007– 2013 *American Journal of Medical Genetics*

Journal Reviewer, 2006– 2014 *Journal of Palliative Care*

Journal Reviewer, 2005– 2013 *Journal of Medical Ethics (BMJ)*

Reviewer. *Ambulatory Pediatric Association's Educational Guidelines for Pediatric Residency*. (Revision), 2003

Editorial Advisory Board: *Children's Health and Safety Magazine*, 2000–2002

Journal Reviewer, 2000–2011. *Ambulatory Pediatrics*

Editor-in-Chief: *Pediatric Rounds: Growth Nutrition Development*, SynerMed, 1991-1995

Journal Reviewer, 1984–2011. *Pediatrics*

### **15.8 Lectures: (Invited – Selected Topics)**

“The New Sexual Revolution: Protecting Children from the Dangers of Comprehensive Sex Education” Mathew Bulfin Educational Conference. Nashville, TN. February 26. 2022

“ACEs & Resilience: Biology of Stress & The Science of Hope” US HHS ACYF & FYSB Conference. *Creating a 2020 Vision*. June 4, 2020

“Telemedicine and School Based Health Centers” Muscogee County Schools SBHC Advisory Committee, June 21, 2018

“Is this the Face of Human Trafficking: Modern Slavery”. Resident/Medical Student Noon Conference. Midtown Medical Center. Columbus Ga. Ga, February 20, 2018

“Human Trafficking – How We Can End It”. Pediatric Grand Rounds – Bon Secours (St. Mary's Hospital) – Richmond, VA, October 31, 2017

“End Human Trafficking Now – Rotary's Role”. Grand Rounds, Columbus Children's Hospital, Columbus, Ga, May 18, 2017

“The Future of Pediatrics”. Columbus Children's Hospital, Columbus, Ga, Grand Rounds, June 23, 2016

“The Newborn Examination”. Philadelphia College of Osteopathic Medicine, Atlanta, Ga, (4 hours for M2 Class), June 7, 2016

“Pediatric Emergencies”. Philadelphia College of Osteopathic Medicine, Atlanta, Ga, (2 hours each for M1 & M2 Classes), April 5, 2016

“Community Roundtable Training on Domestic Minor Sex Trafficking - The Medical Issues”. Columbus State University, April 19, 2016

“Evidence Based Medicine”. Medical Society/Mercer Preceptor Conference, Columbus Regional/MMC, August 22, 2015

“Columbus – A Live Healthy City: Addressing Obesity as a Community.” Carl Patrick Multidisciplinary Symposium, St Francis Hospital. Columbus, Ga, February 2, 2013

“Childhood Obesity and Diabetes.” Columbus Diabetes University 2011, Columbus, Ga,

October 29, 2011

“The Obesity Conundrum.” Georgia Perianesthesia Nurses Association, Peachtree City, Ga, September 17, 2011

“Live Healthy Columbus – Obesity.” Partners in Education Conference, Columbus, Ga, September 7, 2011

“Special Populations: Caring for Chronically Ill Children.” Columbus Metro Medical Response System, Fundamental Disaster Management, Columbus, Ga, September 29, 2010

“Five Things Children Would Change about Emergency Medicine.” Pediatric Grand Rounds, Columbus Regional Healthcare System, Columbus, Ga, September 9, 2010

“Adolescent Brain Development: Legal and Societal Issues.” Catholic Medical Association, Baltimore, Md, October 10, 2008

“Making the Case for Primary Care.” 4<sup>th</sup> Annual NHSC Ambassadors Conference, Keynote Address, Phoenix, Az, July 26, 2008

“The Role of the Ambassador.” 4<sup>th</sup> Annual NHSC Ambassadors Conference, Phoenix, Az, July 25, 2008

“Legal and Societal Issues in Adolescent Health.” 7<sup>th</sup> National Meeting of the Medical Institute, Austin, Texas, July 9, 2008

“Freedom of Conscience in Clinical Practice.” 7<sup>th</sup> National Meeting of the Medical Institute, Austin, Texas, July 8, 2008

“The NIH/NICHHD: An Overview.” Critical Care Pediatric Research Network Committee, Bethesda, Md, March 26, 2008

“How you Gonna Keep ‘em Down on the Farm?: Promoting Primary Care. AMA Section on Medical Schools, November 17, 2007

“Child Prostitution.” National Advisory Council on Sexual Health, Sept 17, 2007

“Religion, Science, and Sexual Health.” National Advisory Council on Sexual Health, Sept 17, 2007

“Internationalism in Medical Education.” BSOM Medical Education Grand Rounds, January 11, 2007

“International Child Health: It’s Not So Healthy.” World Affairs Council of Eastern, NC. Great Decisions Program, 1/27/2007

“Encouraging Students to Primary Care Residencies: Bridging Supply to Meet Demand.” SGSA, April 4, 2007, Little Rock, Arkansas

“Earth Day & 50<sup>th</sup> Anniversary Albert Schweitzer ‘Declaration of Conscience.’” Town Commons Park, Greenville, NC. Sunday, April, 23, 2007

“Encouraging Students to Primary Care.” National Health Services Corp Ambassador Conference, July 26-29, 2007, Memphis, Tennessee

“Vaccines and Sexual Health.” National Advisory Council, National Center for Primary Care, Morehouse School of Medicine, May 8, 2007

“Five Things that Children Would Change about Emergency Medicine.” BSOM, Peds

Emergency Grand Rounds. PCMH Auditorium, August 28, 2007

“Bringing International Health to Eastern North Carolina: Why Should Our Trainees Study Abroad?” World Affairs Councils of Eastern North Carolina, October 2006

“Sexuality and the Media.” – National Advisory Council, National Center for Primary Care, Morehouse SOM, May 23, 2005

“Abstinence Education Programs.” – Medical Institute Annual Conference, Moderator and Commentator, Washington, DC, May 27, 2005

“Why is This Child Coughing?” – 27<sup>th</sup> Annual MCU/VCU Pediatric Primary Care Conference, Virginia Beach, VA. July 23, 2005

“Evaluation of Chronic Abdominal Pain.” Workshop – 27<sup>th</sup> Annual MCU/VCU Pediatric Primary Care Conference, Virginia Beach, VA, July 23, 2005

“Condom Integrity: Research Needs.” – National Advisory Council, National Center for Primary Care, Morehouse SOM, July 26, 2005

“Why is this Child Coughing?” PRO BONO Course – Romania, American College of Chest Physicians and the University of Medicine and Pharmacy, Targu Mures, Romania, September 13, 2005

“Common Pediatric Illnesses Presenting as Rashes.” PRO BONO Course – Romania, American College of Chest Physicians and the University of Medicine and Pharmacy, Targu Mures, Romania, September 13, 2005

“Evaluations of Fever in the Infant.” PRO BONO Course – Romania, American College of Chest Physicians and the University of Medicine and Pharmacy, Targu Mures, Romania, September 13, 2005

“The Role of the General Physician in Child Care.” PRO BONO Course – Romania, American College of Chest Physicians and the University of Medicine and Pharmacy, Targu Mures, Romania, September 13, 2005

“PICU Organization in the United States.” PRO BONO Course – Romania, American College of Chest Physicians and the University of Medicine and Pharmacy, Targu Mures, Romania, September 13, 2005

“Adolescent Brain: Implications of Sexuality Education.” – Catholic Medical Association, 74<sup>th</sup> Annual Conference, Portland, OR, October 21, 2005

“The Declining Number of Generalists – Challenges in Medical Education.” (with Bruce Johnson, MD), Workshop – Generalists in Medical Education Meeting, Washington, DC, November 5–6, 2005

“Health Disparities and the Uninsured.” – AMSA Region 5 Conference, Durham, NC, March 6, 2004

“The Diagnosis of ADHD Pediatrician’s Role.” – International Pediatric Congress, Cancun, Mexico, August 17, 2004

“Primary Care of Infants.” – International Pediatric Congress, Cancun, Mexico, 8/20/2004

“The Developing World is Close to Home.” – UNCC AMSA Chapter, Charlotte, NC, September 10, 2004

“A Medical Practice Initiative.” – National Advisory Council, National Center for

Primary Care, Morehouse SOM, September 21, 2004

“Lysosomal Storage Disorders.” – The LSD Education Initiative, San Francisco, CA, October 9, 2004

“Sexuality Education in the Schools.” – Section on School Health Symposium, AAP NCE, San Francisco, CA, October 10, 2004

“It Takes a Village: The Importance of Family in the Rearing of Children.” – Annual Conference, Virginia Chapter, American Academy of Pediatrics, and the Children’s Hospital of the King’s Daughters, Williamsburg, VA, October 3–5, 2003

“The Telephone in Pediatric Practice.” – Pediatric Grand Rounds, University of Illinois Medical School at Rockford, Rockford, IL, February 15, 2002

“Child Abuse.” – Pediatric Grand Rounds, Alexian Brothers Medical Center, March 16, 2001

“The Future of Pediatrics.” – Slovenian Pediatric Association, via Teleconference, March, 2001

“Child Abuse.” – Annual Convocation, University of Medicine and Pharmacy, Targu-Mures, Romania, May 18–21, 2001

“The Role of the Department Chair.” – International Pediatric Chairs Association Meeting, Beijing, China, September 8–9, 2001

“Pediatrics in the New Millennium.” – Pediatric Grand Rounds, Jersey Shore Medical Center, Neptune, NJ, October 5, 2001

“Problems in the Practice of Pediatrics.” – Department of Pediatrics Meeting, Elmhurst Hospital, Elmhurst, Illinois, March 28, 2000

“Child Abuse.” – Pediatric Grand Rounds, Rush Medical School, 8/13, 2000

“Child Abuse.” – Pediatric Grand Rounds, Lutheran General Children’s Hospital, 8/22/2000

“Children of the World – An Underrepresented Minority” – The Shantilal C. Sheth Oration, 35th National Conference of The Indian Academy of Pediatrics, Kochi, India, January 8–11, 1998

“Development of Emergency Services in Pediatrics.” – 35th National Conference of Indian Academy of Pediatrics, Kochi, India, January 8–11, 1998

“Child Abuse: The Pediatrician Role.”, “Telephone in Pediatric Practice.” and “Cervical Spine Trauma – A Rational Approach to Diagnosis.” – 45th Annual Meeting of the Pediatric Section, Puerto Rico Medical Association, San Juan, Puerto Rico, February 13–16, 1998

“The Plight of Children and the Role of National Pediatric Organizations.” – 18th Pan American Pediatric Congress, Santiago, Chile, April 27, 1998

“Title XXI – What is the AAP Doing.” – Pediatric Academic Societies’ Annual Meeting, New Orleans, LA, May 4, 1998

“Presentation on the 10th Anniversary of the CHIP Program.” Keynote Speaker. – Child Health Investment Partnership (CHIP) 10th Anniversary, Roanoke, Virginia, June

4,1998

- “Child Abuse.” – Louisiana Association of Nationally Registered Emergency Medical Technicians Educational Conference, Kenner, Louisiana, June 12–14, 1998.
- “Minorities, Media and the AAP.” – National Medical Association, Annual Meeting, New Orleans, Louisiana, August 1–5, 1998
- “Pediatric AIDS, The Role of Pediatric Societies in Policy Making.” – XX Congress of the Federation of Pediatric Associations of Central America and the Caribbean, Panama City, Panama, November 16-18, 1998
- “The Interconnectedness of Risky Behaviors.” – Right Choices for Youth Conference, sponsored by Gov. George Bush, Austin, Texas – March 31, 1998
- “Pediatrics Now and in the 21st Century.” Visiting Professor – University of South Florida, February 6, 1997
- “Pediatric Emergency Medicine in the USA.” and “The Changing World of Academic Pediatrics.” – Italian Pediatric Society, Bologna, Italy, June 13–16, 1997
- “AAP Update.”, “Telephone in Pediatric Practice.”, “Child Abuse.” and “Guns and Children.” – Seventh Annual Pediatric Symposium, Joe DiMaggio Children’s Hospital, Fort Lauderdale, Florida, November 8–9, 1997
- “Guns and Children: A Pediatric Epidemic.” – Grand Rounds, All Children’s Hospital, St. Petersburg, Florida, December 12, 1997
- “Health Care Reform.” “Violence and Children – The Gun Epidemic.” “Child Abuse – The Physician’s Role.” – Medical College of Georgia Annual Pediatric CME Conference, St. Simon Island, GA, July 18–20, 1994
- “Adolescent Health: Strategies for Improving Health Status.” speaker and panel moderator – Children’s Defense Fund National Conference, Washington, DC, March 11, 1988
- “Meeting the Health Care Needs of Children in Schools.” Keynote Address – National Association of School Nurses, Anaheim, CA, June 28, 1988
- “School Based Clinics, Another View.” – American Academy of Pediatrics Annual Meeting, New Orleans, LA, November 1–3, 1987
- “Tort Reform.” – American Academy of Pediatrics Annual Meeting, New Orleans, LA, November 1–3, 1987
- “School Based Health Clinics – Problems For the Future” and Panel Commentator for Research Papers on School Health Clinics – American Public Health Association Annual Meeting – Las Vegas, NV, September 29–30, 1986
- “School Health” – Keynote address, Annual Conference on School Health, Yale University School of Medicine, New Haven, CT, March 20, 1985
- “Health Care for the School-Aged Child in the Next Decade.” – National Conference on Health of the School Aged Child, April 12–14, 1984, Denver, CO
- “Health Care of the School Aged Child” – National Maternal and Child Health Conference, Tyson’s Corner, Virginia, March 17, 1982



“Health Education Process and Methodology: What It Is and How It's Done.” – First National Conference on Rural Health Education, May 2–4, 1978, St. Louis, Missouri

Zanga, J.R. and Martinez, J.: “Pathologic Analysis on Werdnig–Hoffman Disease Presenting as Diaphragmatic Paralysis: Report of a Case.” – Cuban Medical Association Congress, Miami, Florida, 1975

**15.9 Other: (Selected Items)**

*CBS This Morning*, August 23, 1994 Video Parenting Magazine, Nationally syndicated, 15 segments, 2001–2003

“House Call” – Monthly segment of *Noon News*, WWBT–TV Channel 12, 1991–1996

Volunteer Medical Director, Camp Easter Seal East, 1985–1996

Consultant – Pediatric Program Organization, St. Joseph's Hospital, Phoenix, AZ, March 23–25, 1994

*Good Morning America*, September, 1990

Consultant – National Institutes for Mental Health – To develop AIDS Publication for Primary Care Physician, 1986–1987

“A Visit With the Pediatrician” – Weekly segment of *Good Morning Virginia*, WXEX–TV, Channel 8. 1980–1985

Regular Pediatric Columnist – *Woman's World Magazine*, 1980–1984

**16. GRANTS AS PRINCIPAL INVESTIGATOR**

“Caring for the Elderly: House Calls.” Pitt Memorial Hospital Foundation, 2008–2009  
\$15,770

“Office of Generalist Programs.” PCMH, Pitt County Memorial Hospital, 2002– 2008,  
\$78,000 per year

“Childhood Injury Prevention for Family Daycare.” DHHS, Maternal and Child Health Bureau, 1992–1993, \$19,872

“Residency Training in General Internal Medicine and/or General Pediatrics.” DHHS, U.S.

“Injury Prevention Grant.” Virginia Department of Health, DMCH,  
1987–1996, \$185,000 per year

“Child Development Services.” Virginia Department of Health, DMCH,  
1988–1993, \$165,000 per year

“Behavioral Pediatric Training Program.” DHHS, Maternal and Child Health Services,  
1986–1992, \$630,000

“Virginia Auto Safety Alliance. Traffic Safety Now.” 1986 and 1987, \$300,000,

“Community Grant” US Public Health Service, 1985–1988, \$475,000 plus indirect costs)

Updated: 9/12/2022

## Appendix Attachment

11

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF FLORIDA  
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.,

Plaintiffs,

v.

Case No. 4:22-cv-00325-RH-MAF

SIMONE MARSTILLER, et al.,

Defendants.

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**Expert Declaration of Michael K. Laidlaw, MD**

I, Michael K. Laidlaw, M.D., hereby declare as follows:

1. I am over the age of eighteen and submit this expert declaration based on my personal knowledge and experience.
2. I am a board-certified endocrinologist. I received my medical degree from the University of Southern California in 2001. I completed my residency in internal medicine at Los Angeles County/University of Southern California Medical Center in 2004. I also completed a fellowship in endocrinology, diabetes and metabolism at Los Angeles County/University of Southern California Medical Center in 2006.
3. The information provided regarding my professional background and publications are detailed in my curriculum vitae. A true and correct copy of my curriculum vitae is attached as Exhibit A.
4. In my clinical practice as an endocrinologist, I evaluate and treat patients with hormonal and/or gland disorders. Hormone and gland disorders can cause or be associated with psychiatric symptoms, such as depression, anxiety, and other psychiatric symptoms. Therefore, I frequently assess and treat patients demonstrating psychiatric symptoms and determine whether their psychiatric symptoms are being caused by a hormonal issue, gland issue, or something else.

5. I have been retained by Defendants in the above-captioned lawsuit to provide an expert opinion on the efficacy and safety of sex reassignment treatment.

6. If called to testify in this matter, I would testify truthfully and based on my expert opinion. The opinions and conclusions I express herein are based on a reasonable degree of scientific certainty.

7. I am being compensated at an hourly rate of \$450 per hour plus expenses for my time spent preparing this declaration, and to prepare for and provide testimony in this matter. I am being compensated at an hourly rate of \$650 for testimony at depositions or trial. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

8. My opinions contained in this report are based on: (1) my clinical experience as an endocrinologist; (2) my clinical experience evaluating individuals who have or have had gender incongruence including a detransitioner; (3) my knowledge of research and studies regarding the treatment of gender dysphoria, including for minors and adults; and (4) my review of the various declarations submitted by Plaintiffs

9. I was provided with and reviewed the following case-specific materials: The Florida Medicaid's "Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria"; the expert declaration of Johanna Olson-Kennedy; the expert declaration of Loren Schechter; the expert declaration of Dan H. Karasic; the expert declaration of Armand H. Matheny Antommaria; the declaration of Brit Rothstein; the declaration of August Dekker; the declaration of Jane Doe; the declaration of Jade Ladue; files from Florida Medicaid.

10. In my professional opinion, treatment interventions on behalf of children and adults diagnosed with gender dysphoria must be held to the same scientific standards as other medical treatments. These interventions must be optimal, efficacious, and safe. Any treatment which alters biological development in children should be used with extreme caution. Except in the case of a fatal injury or disease, the minor will become an adult and present to the adult physician. The adult physician must be able to have a thorough understanding of any condition which alters the biological development of children and, in the case of the endocrinologist, be knowledgeable about the long term effects of hormones

on the human body, particularly when the hormones are being used in ways that alter development.

11. The following expresses my expert opinion regarding minors and adults who present with a disparity between their biological sex and internal feeling about their gender, specifically with regard to the use of social transition, medications which block normal pubertal development, the applications of hormones of the opposite sex, and surgical procedures that alter the genitalia and/or breasts for those individuals.

## **I. Background**

### **A. Endocrine Disorders**

Before discussing gender dysphoria and gender affirmative therapy from the perspective of an endocrinologist, it is helpful to discuss the background of endocrine diseases. This background demonstrates the difference in gender dysphoria, which is a psychological diagnosis, and other conditions treated by endocrinologists, which are physical diagnoses.

Endocrinology is the study of glands and hormones. Endocrine disorders can be divided into three main types: those that involve hormone excess, those that involve hormone deficiency, and those that involve structural abnormalities of the glands such as cancers.

It is important for the endocrinologist to determine the cause of hormone gland excess or deficiency in order to devise an appropriate treatment plan. The plan will generally be to help bring the hormones back into balance and thus bring the patient back to health.

To give an example of hormone excess, hyperthyroidism is a term which means overactivity of the thyroid gland. In this condition excess thyroid hormone is produced by the thyroid gland. This results in various physical and psychological changes for the afflicted patient. Examples of physical changes can include tachycardia or fast heart rate, hand tremors, and weight loss. Examples of psychological symptoms include anxiety, panic attacks, and sometimes even psychosis.

An endocrinologist can recognize thyroid hormone excess in part by signs and symptoms, but can also confirm the diagnosis with laboratory testing that shows the thyroid hormones to be out of balance. Once this is determined and the degree of excess is known, then

treatments can be given to bring these levels back into balance to benefit the patient's health and to prevent other disease effects caused by excess hormone.

To give another example, consider a deficiency of insulin. Insulin is a hormone which regulates blood glucose levels. If there is damage to the pancreas such that insulin levels are very low, then blood glucose levels will rise. If the glucose levels rise to a certain abnormally high level, then this is considered diabetes. In the case of type 1 diabetes, insulin levels are abnormally low and therefore blood glucose levels are abnormally high leading to a variety of signs and symptoms. For example, the patient may have extreme thirst, frequent urination, muscle wasting, and weight loss. They may often experience lethargy and weakness.

In this case laboratory tests of glucose and insulin levels can confirm the diagnosis. Once diabetes is confirmed, the patient is then treated with insulin to help restore glucose balance in the body and prevent long-term complications of diabetes.

To give an example of a structural abnormality, a patient may have a lump on the thyroid gland in the neck. This may be further examined by an imaging test such as an ultrasound. A needle biopsy can be performed so that the cells can be examined under a microscope. A trained medical professional such as a pathologist can then examine the cells to determine if they are benign or cancerous. In the case of a thyroid cancer, a surgical procedure known as a thyroidectomy may be performed to remove the diseased thyroid gland in order to treat the cancer.

Noteworthy in the preceding three examples is that all three disease conditions are diagnosed by physical observations. In other words, a laboratory test of a hormone, an imaging test of an organ, an examination of cells under a microscope, or all three may be employed in the diagnosis of endocrine disease.

### **B. Gender Dysphoria is a Psychological Diagnosis**

Gender dysphoria, on the other hand, is not an endocrine diagnosis, it is in fact a psychological diagnosis. It is diagnosed purely by psychological methods of behavioral observation and questioning.

Likewise what is termed gender identity is a psychological concept. It has no correlate in the human body. In the letter to the editor I wrote with my colleagues, discussed above, we

wrote in our critique of the Endocrine Society Guidelines that "There are no laboratory, imaging, or other objective tests to diagnose a 'true transgender' child" (Laidlaw et al., 2019).

For example, one cannot do imaging of the human brain to find the gender identity. Likewise, there is no other imaging, laboratory tests, biopsy of tissue, autopsy of the brain, genetic testing, or other biological markers that can identify the gender identity. There is no known gene that maps to gender identity or to gender dysphoria. In other words, there is no objective physical measure to identify either gender identity or gender dysphoria.

This is in contrast to all other endocrine disorders which have a measurable physical change in either hormone levels or gland structure which can be confirmed by physical testing. Therefore, gender dysphoria is a purely psychological phenomenon and not an endocrine disorder. But as my colleagues and I wrote in our letter to the editor, it becomes an endocrine condition through gender affirmative therapy: "Childhood gender dysphoria (GD) is not an endocrine condition, but it becomes one through iatrogenic puberty blockade (PB) and high-dose cross-sex (HDGS) hormones. The consequences of this gender-affirmative therapy (GAT) are not trivial and include potential sterility, sexual dysfunction, thromboembolic and cardiovascular disease, and malignancy" (Laidlaw et al. 2019).

As a practicing endocrinologist and scientist, I have made a study of GD and its treatment for two reasons: 1) I want to be sure that my colleagues and I understand the science before we treat any patients with GD; and 2) I am concerned that the medical society that claims to speak for me and other endocrinologists has abandoned scientific principles in endorsing treatments for GD that have questionable scientific support. The opinions expressed in this report are the result of my own experience, studies, education, and review of the scientific literature related to GD.

### **C. Gender Dysphoria and Desistance**

GD is a persistent state of distress that stems from the feeling that one's gender identity does not align with their physical sex (American Psychiatric Association, 2013). It has been a relatively rare condition in children and adolescents. However there have been very significant increases in referrals for this condition noted around the globe.

For example, in the UK, "The number of referrals to GIDS [Gender Identity Development Service] has increased very significantly in recent years. In 2009, 97 children and young

people were referred. In 2018 that number was 2519" (Bell v Tavistock Judgment, 2020). There is evidence that this increase may be in part due to social contagion and fueled by social media/internet use (Littman, 2018).

The French National Academy of Medicine wrote recently: "Parents addressing their children's questions about transgender identity or associated distress should remain vigilant regarding the addictive role of excessive engagement with social media, which is both harmful to the psychological development of young people and is responsible for a very significant part of the growing sense of gender incongruence" (SEGM, 2022).

In "a study of the Finnish gender identity service, '75% of adolescents [assessed] had been or were currently undergoing child and adolescent psychiatric treatment for reasons other than gender dysphoria' (Kaltiala-Heino, 2015). In fact, '68% had their first contact with psychiatric services due to other reasons than gender identity issues.' The same study also showed that 26% percent had an autistic spectrum disorder and that a disproportionate number of females (87%) were presenting to the gender clinics compared to the past" (Laidlaw in gdworkinggroup.org, 2018).

Desistance is a term indicating that the child, adolescent, or adult who initially presented with gender incongruence has come to experience a realignment of their internal sense of gender and their physical body. "Children with [gender dysphoria] will outgrow this condition in 61% to 98% of cases by adulthood. There is currently no way to predict who will desist and who will remain dysphoric" (Laidlaw et al., 2019; Ristori & Steensma, 2016).

Because there is no physical marker to diagnose gender identity, and because it is not possible to predict which child or adolescent will desist, it is not possible to know which young person will remain transgender identified as adults. Also, because the rate of desistance is so high, gender affirmative therapy will necessarily cause serious and irreversible harm to many children and adolescents who would naturally outgrow the condition if not affirmed.

Dr. Olson-Kennedy states that "[t]he studies pertaining to desistance upon which the GAPMS Memo relies pertain to prepubertal youth, not adolescents. In fact, contrary to the GAPMS Memo's assertion, studies show that if gender dysphoria is present in adolescence, it usually persists (DeVries, et al., 2011)." (Olson-Kennedy decl, p. 22).



Dr. Olson-Kennedy confuses prepubertal (a medical term) with preadolescence (a psychological designation). Puberty which pertains to the physical development of the reproductive tract, breasts and associated secondary sex characteristics can begin as early as age 8 in girls and age 9 in boys. The studies which have examined desistance involved children aged twelve and under. For example table 1 in Ristori and Steensma 2016 shows multiple studies involving children. For the three most recent - Singh (2012), Wallien & Cohen-Kettenis (2008), and Drummond et al. (2008) - these involved age ranges from 3 to nearly 13 years old.<sup>1</sup> The desistance rate varied from 61 to 88%. Since the upper age was twelve (or slightly higher), this would include children in the age range of 8-12 years old many of whom were going through puberty based on their age and were therefore not Tanner stage 1 (pre-pubertal).<sup>2</sup> Therefore Dr. Olson-Kennedy's statement that "[t]he studies pertaining to desistance upon which the GAPMS Memo relies pertain to prepubertal youth" is incorrect.

#### **D. Biological Sex in Contrast to Gender Identity**

A recognition and understanding of biological sex is critical to my practice as an endocrinologist because the endocrine physiology of men and women, boys and girls, differ.

Biological sex is the objective physical condition of having organs and body parts which correspond to a binary sex. There are only two physical sexes, male and female. The male is identified as having organs and tissues such as the penis, testicles and scrotum. The female sex is identified by having organs and tissues such as the labia, vagina, uterus, and ovaries. Biological sex is easily identified by physical observation such that adults and even young children can identify the biological sex of a newborn baby.

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<sup>1</sup> "This study provided information on the natural histories of 25 girls with gender identity disorder (GID). Standardized assessment data in childhood (mean age, 8.88 years; range, 3-12 years)" (Drummond et al., 2008).

"The mean age of the participating gender-referred children was 10.47 years (SD = 1.27; range, 8.11–12.77)" (Wallien et al., 2009).

" Standardized assessment data in childhood (mean age, 7.49 years; range, 3–12 years) and at follow-up (mean age, 20.58 years; range, 13–39 years) were used to evaluate gender identity and sexual orientation outcome. At follow-up, 17 participants (12.2%) were judged to have persistent gender dysphoria." (Singh, 2012).

<sup>2</sup> To my knowledge the desistance literature does not examine Tanner stages of puberty as part of their studies. However one can infer based on the ages that many children had at least begun puberty (Tanner stage 2) or were at a more advanced stage of puberty.

This is in contrast to gender identity, which does not exist in any physical sense. It is a subjective identification known only once a patient makes it known. It cannot be identified by any physical means, cannot be confirmed by any outside observer, and can change over time.

It is also noteworthy that the physical organs described above as representing biological sex have a physical genetic correlate. In other words, it is a well-established scientific fact that two X chromosomes identify the cells correlating to a female person, and an X and a Y chromosome correlate to a male person.

Sex is clearly identified in 99.98% of cases by chromosomal analysis (Sax, 2002). Sex is also clearly recognized at birth in 99.98% of cases (Id.). Therefore, sex is a clear provable objective reality that can be identified through advanced testing such as karyotyping, or simple genital identification at birth by any layperson. The other 0.02% of cases have some disorder of sexual development (DSD). DSDs do not represent an additional sex or sexes, but simply a disorder on the way to binary sex development (Chan et al., 2021).

## **E. Human Sexual Development**

### **1. Embryologic development**

Another confirmation that there are only two biological sexes comes from what is known about embryologic development and fertilization. The biologic development of the human person begins with a gamete from a female termed an ovum or egg and a gamete from a biological male which is termed sperm. The fertilization of the egg by the sperm begins the process of human biological development. The cells of the fertilized ovum then multiply and the person undergoes the incredible changes of embryologic development.

It is noteworthy that the male sperm comes from the biological male and the female egg comes from the biological female. There is no other third or fourth or fifth type of gamete that exists to begin the development of the human person. This is consistent with the binary nature of human sex (Alberts et al., 2002).

The sex binary of the human embryo is further developed between roughly weeks 8 to 12 of human development. There are two primitive structures present within the developing embryo called the Wolffian duct and Mullerian ducts (Larsen et al., 2003). The Wolffian ducts develop into substructures of the genitalia including the vas deferens and epididymis

which belong exclusively to the male sex. For the female, the Mullerian ducts go on to form the uterus, fallopian tubes, cervix and upper one third of the vagina which belong exclusively to the female sex (Id.)

Significantly once the male structures are developed from Wolffian ducts, the Mullerian ducts are obliterated. This means that throughout the rest of embryological development the Mullerian ducts will not form into biological female structures. Likewise, in the female, the Wolffian ducts are destroyed by week 12 and will not form male structures at any point in the future (Id.).

Thus we can see in very early development that the sex binary is imprinted physically not only in the chromosomes, but also on the very organs that the body produces. Additionally, the potential to develop organs of the opposite sex is eliminated. Thus, in the human being there are only two physical tracts that one may progress along, the one being male and the other being female (Wilson and Bruno, 2022).

## **2. Pubertal Development**

As mentioned previously, at the time of birth an infant's sex is easily identified through observation of the genitalia. Corresponding internal structures could also be confirmed through imaging if needed.

In early childhood, some low level of sex hormones are produced by the sex glands. The male testes produce testosterone. The female ovaries produce primarily the hormone estrogen. These sex glands remain quiescent for the most part, producing low levels of sex hormones until the time of pubertal development.

Puberty is a time of development of the sex organs, body, brain and mind. There are well known changes in physical characteristics of the male such as growth of facial hair, deepening of the voice, and increasing size of the testicles and penis. Importantly the testicles will develop sperm under the influence of testosterone and become capable of ejaculation. Because of these changes, the male will become capable of fertilizing an egg. The inability to produce sperm sufficient to fertilize an egg is termed infertility.

For the female, pubertal development includes changes such as breast development, widening of the pelvis, and menstruation. The female will also begin the process of ovulation which is a part of the menstrual cycle and involves the release of an egg or eggs

from the ovary. Once the eggs are released in a manner in which they can become fertilized by human sperm then the female is termed fertile. The inability to release ovum that can be fertilized is infertility (Kuohong and Hornstein, 2021).

### **3. Tanner stages of development**

From a medical perspective it is important to know the stage of pubertal development of the developing adolescent. This can be determined through a physical examination of the body. The female will have changes in breast characteristics and pubic hair development. Similarly, the male will have changes in testicular size and pubic hair development. These findings can be compared to the Tanner staging system which will allow the stage of puberty to be known.

Tanner stages are divided into five. Stage 1 is the pre-pubertal state before pubertal development of the child begins. Stage 5 is full adult sexual maturity. Stages 2 through 4 are various phases of pubertal development (Greenspan and Gardner, 2004).

Awareness of the Tanner stage of the developing adolescent is also useful to assess for maturation of sex organ development leading to fertility. For girls, the first menstruation (menarche) occurs about two years after Tanner stage 2 and will typically be at Tanner stage 4 or possibly 3 (Emmanuel and Boker, 2022). The first appearance of sperm (spermarche) will typically be Tanner stages 4 (Id.). If puberty is blocked or disrupted before reaching these critical stages, the sex glands will be locked in a premature state and incapable of fertility.

### **4. Biological Sex Cannot Be Changed**

It is not possible for a person to change from one biological sex to the other, and there is no technology that allows a biological male to become a biological female or vice-versa. It is not technologically possible at this time to change sex chromosomes; these will remain in every cell throughout life. It is not technologically possible to transform sex glands from one to the other. In other words, there are no hormones or other means currently known to change an ovary into a testicle or a testicle into an ovary.

Furthermore, as noted earlier, several of the sex specific structures (such as the epidymis of the male or uterus of the female) are produced early in embryological development from around weeks 8 to 12. The primitive ducts which lead to these organs of the opposite sex

are obliterated. There is no known way to resuscitate these ducts and continue development of opposite sex structures.

It is also not possible to produce gametes of the opposite sex. In other words, there is not any known way to induce the testicles to produce eggs. Nor is there any known way to induce the ovaries to produce sperm. Therefore, creating conditions for a biological female to create sperm capable of fertilizing another ovum is impossible. The induction of opposite sex fertility is impossible.

In fact, as I will discuss, gender affirming therapy actually leads to infertility and potential sterilization.

### **F. Iatrogenic Harms**

The term iatrogenic is used in medicine to describe harms or newly created medical conditions that are the result of medications, surgeries, or even psychological treatments. In this section I will discuss the iatrogenic harms of “gender affirmative treatment,” for females. Each of the four interventions which I will describe (social transition, blocking normal puberty, opposite sex hormones, and surgery) lead to iatrogenic harms to the patient. These harms will be described in detail below. I speak of these harms because it is important to understand that once a patient begins GAT it is more likely the patient will continue on to surgery (de Vries et al., 2014). Thus, GAT interrupts the natural desistance process and instead places the patient on a lifetime regimen of hormonal and surgical care. A good understanding of these harms is also critical to my practice as an endocrinologist, because if I did not understand these harms, I could not advise patients of the risks associated with GAT.

### **G. Gender Affirmative Therapy**

The approaches to gender dysphoria in minors may be divided into three main types. (Zucker, 2020). One is psychosocial treatment that helps the young person align their internal sense of gender with their physical sex. Another would be to "watch and wait" and allow time and maturity to help the young person align sex and gender through natural desistance. The third option, which is the focus of that which follows, is referred to as gender affirmative therapy.

Gender affirmative therapy (GAT) of adults and minors consists of psychosocial, medical, and surgical interventions that attempt to psychologically and medically alter the patient so that they come to believe they may become similar to the physical sex which aligns with their gender identity (but not their biological sex) and thereby reduce gender dysphoria. GAT consists of four main parts: 1) social transition, 2) blocking normal puberty or menstruation, 3) high dose opposite sex hormones, and 4) surgery of the genitalia and breasts.

The application of this medical therapy to minors is a fairly new intervention and is associated with a number of harms both known and unknown. GAT suffers from a lack of a quality evidence-base, poorly performed studies, and ongoing unethical human experimentation.

### **1. Social transition**

The first stage of gender affirmative therapy is termed social transition. Social transition is a psychological intervention. The child may be encouraged to adopt the type of clothing and mannerisms or behaviors which are stereotypical of the opposite sex within a culture. For example, in the United States a boy might wear his hair long and wear dresses in order to socially transition. A girl may cut her hair short and wear clothes from the boys' section of a department store.

Social transition of the child has been noted by expert researcher in the field of child gender dysphoria, Ken Zucker, to itself be a form of iatrogenic harm (Zucker, 2020). This is because the social transition process may solidify the young person's belief that they are in fact the sex opposite of their biological sex.

From an endocrine point of view, it is understandable that a child having the outward appearance of the opposite sex, would believe that he or she is destined to go through puberty of the opposite sex as they have only a poor understanding of the internal structures of the body, the function of the sex glands, the role of the sex glands in fertility and so forth.

Therefore, it would be quite frightening for a boy who believes he is a girl to be turning into a man with all of the adult features that accompany manhood. Vice versa, the girl who has become convinced that she is a boy will be frightened by the physical changes brought on by womanhood.

In fact, it would appear that in the minds of the children and adolescents that they are anticipating a sort of disease state in the future by the hormone changes that will occur as a normal and natural part of human development. Until relatively recently in human history, it has not been possible to interfere with puberty through pharmaceutical means.

## **2. Medications which Block Pubertal Development**

### **a. Background**

A second stage of gender affirmative therapy may involve blocking normal pubertal development. This may be done with puberty blocking medications that act directly on the pituitary.

In order to understand what is occurring in this process, it is helpful to be aware of normal hormone function during pubertal development.

There is a small pea-sized gland in the brain called the pituitary. It is sometimes referred to as the "master gland" as it controls the function of several other glands. One key function for our purposes is the control of the sex glands. There are two specific hormones produced by the pituitary referred to as luteinizing hormone (LH) and follicle stimulating hormone (FSH). These are responsible for sex hormone production and fertility. The LH and FSH act as signals to tell the sex glands begin or continue their function.

In the adult male, the production of LH will cause adult levels of testosterone to be produced by the testicles. In the adult female, the production of LH will cause adult levels of estrogen to be produced by the ovaries.

In early childhood, prior to the beginning of puberty, the pituitary function with respect to the sex glands is quiescent. However, during pubertal development LH will signal the testicle to increase testosterone production and this carries the boy through the stages of pubertal development into manhood. Likewise for the female, the interaction of LH with the ovaries increases estrogen production and carries the girl through the stages of development into womanhood.

There are conditions diagnosed by endocrinologists which involve a disruption of this normal communication between the pituitary and the sex glands. There is a medical condition called hypogonadotropic hypogonadism. The meaning of this term is that the pituitary is not sending the hormonal signals (LH and FSH) to the sex glands and therefore the sex glands are unable to make their sex hormones. The result is hormonal deficiencies of LH, FSH, and either testosterone or estrogen.

If this condition occurs during puberty, the effect will be to stop pubertal development. This is a disease state which is diagnosed and treated by the endocrinologist.

Medications such as GnRH agonists act on the pituitary gland to lower the pituitary release of LH and FSH levels dramatically. The result is a blockage of the signaling of the pituitary to the testicles or ovaries and therefore underproduction of the sex hormones. This will stop normal menstrual function for the female and halt further pubertal development. For the male this will halt further pubertal development. If the male had already reached spermarche, then production of new sperm will stop.

#### **b. GnRH Agonist Medication Effects Vary by Use Case**

There are a variety of uses for GnRH agonists. The use and outcome can be very different for different applications.

For example, the initial development of the medication called Lupron was for the treatment of prostate cancer. The idea being that blocking pituitary hormones will block the adult male's release of testosterone from the testicles. Since testosterone will promote the growth of prostate cancer, the idea is to lower testosterone levels to a very low amount and therefore prevent the growth and spread of prostate cancer. This is a labeled use of the medication. In other words, there is FDA approval for this use.

Another labeled use of GnRH agonist medication is for the treatment of central precocious puberty. In the disease state of central precocious puberty, pituitary signaling is activated at an abnormally young age, say age four, to begin pubertal development. In order to halt puberty which has begun at an abnormally early time, a GnRH agonist may be used. Here the action of the medication on the pituitary will disrupt the signaling to the sex glands, stop early sex hormone production, and therefore stop abnormal pubertal development.



Then, at a more normal time of pubertal development, say age 11, the medication is stopped and puberty is allowed to proceed. The end result is to restore normal sex gland function and timing of puberty. This is a labeled use for a GnRH agonist medication.

What about the use of puberty blockers such as Lupron in gender affirmative therapy? In these cases, we have physiologically normal children who are just beginning puberty or are somewhere in the process of pubertal development. They have healthy pituitary glands and sex organs. However, a puberty blocking medication is administered to stop normal pubertal development.

In this case the condition of hypogonadotropic hypogonadism described above (a medical disease) is induced by medication and is an iatrogenic effect of treating the psychological condition of gender dysphoria. GnRH agonist medications have not been FDA approved for this use.

### **c. Adverse Health Consequences of Blocking Normal Puberty**

There are a number of serious health consequences that occur as the result of blocking normal puberty. The first problem is infertility. The Endocrine Society Guidelines recommend beginning puberty blockers as early as Tanner stage 2. As discussed earlier, this is the very beginning of puberty. Fertility development happens later generally in Tanner stage 4. One can see that if the developing person is blocked at Tanner stage 2 or 3 as advocated by the guidelines, this is prior to becoming fertile. The gonads will remain in an immature, undeveloped state.

Dr. Antommaria writes that “The [Endocrine Society] guideline recommends that informed consent for pubertal blockers and gender-affirming hormones include a discussion of the implications for fertility and options for fertility preservation (Antommaria decl, p.23). However, even though procedures to preserve fertility are available, studies show that less than 5% of adolescents receiving GAT even attempt fertility preservation (FP) (Nahata, 2017). Moreover, “ovarian tissue cryopreservation is still considered experimental in most centers and testicular tissue cryopreservation remains entirely experimental. These experimental forms of FP would be the only options in children [with puberty] blocked prior to spermarche and menarche and are high in cost and limited to specialized centers. Even with FP there is no guarantee of having a child” (Laidlaw, Cretella, et al., 2019).

Naturally, these children are at a developmental age where they are not thinking about adult related concepts such as having children as they are children themselves. This is only natural and to be expected. The medical problem imposed on them is that if they remain blocked in an early pubertal stage then even the addition of opposite sex hormones will not allow for the development of fertility. In fact, high dose opposite sex hormones may permanently damage the immature sex organs leading to sterilization. Certainly the removal of the gonads, which will be discussed later, will ensure sterilization.

Another problem with blocking puberty at an early stage is sexual dysfunction. The child will continue their chronological age progression toward adulthood and yet remain with undeveloped genitalia. This will lead to sexual dysfunction including potential erectile dysfunction and inability to ejaculate and orgasm for of the male. For the female with undeveloped genitalia potential sexual dysfunction may include painful intercourse and impairment of orgasm.

The impairment of sexual function was evident in the TLC reality show "I am Jazz". In the show Jazz who was identified male at birth has been given puberty blockers at an early pubertal stage. In an episode where Jazz visits a surgeon and has a discussion about sexual function, Jazz states: "I haven't experienced any sexual sensation." Regarding orgasm, Jazz says: "I don't know, I haven't experienced it"<sup>3</sup> (TLC, accessed 2022).

In addition to direct effects on the developing genitalia and fertility there are other important aspects of puberty that are negatively affected. For example, puberty is a time of rapid bone development. This time of development is critical in attaining what we call peak bone density or the maximum bone density that one will acquire in their lifetime (Elhakeem, 2019).

Any abnormal lowering of sex hormones occurring during this critical time will stop the rapid accumulation of bone and therefore lower ultimate adult bone density. If a person does not achieve peak bone density, they would be expected to be at future risk for osteoporosis and the potential for debilitating spine and hip fractures as adults. Hip fractures for the older patient very significantly increase the risk of major morbidity and death (Bentler, 2009). Allowing a "pause" in puberty for any period of time leads to an inability to attain peak bone density.

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<sup>3</sup> Jazz's age is somewhere in the mid-teens during this episode.

Another consideration is maturation of the human brain. Much of what happens is actually unknown. However, “sex hormones including estrogen, progesterone, and testosterone can influence the development and maturation of the adolescent brain” (Arain, 2013). Therefore there are unknown, but likely negative consequences to blocking normal puberty with respect to brain development.

A third major problem with blocking normal puberty involves psychosocial development. Adolescence is a critical time of physical, mental, and emotional changes for the adolescent. It is important that they develop socially in conjunction with their peers. This is well recognized in the psychological literature: “For decades, scholars have pointed to peer relationships as one of the most important features of adolescence.” (Brown, 2009). If one is left behind for several years under the impression that they are awaiting opposite sex puberty, they will miss important opportunities for socialization and psychological development. Psychosocial development will be necessarily stunted as they are not developing with their peers. This is a permanent harm as the time cannot be regained.

Aside from the multiple serious problems that are iatrogenically acquired by blocking normal puberty, there appear to be independent risks of the puberty blocking medication themselves. For example, one can read the labeling of a common puberty blocking medication called Lupron Depot-Ped and find under psychiatric disorders: “emotional lability, such as crying, irritability, impatience, anger, and aggression. Depression, including rare reports of suicidal ideation and attempt. Many, but not all, of these patients had a history of psychiatric illness or other comorbidities with an increased risk of depression” (Lupron, 2022). This is particularly concerning given the high rate of psychiatric comorbidity with gender dysphoria discussed previously.

#### **d. The Effect of Puberty Blockers on Desistance**

As stated earlier a very high proportion of minors diagnosed with gender dysphoria will eventually desist or come to accept their physical sex. Puberty blockers have been shown to dramatically alter natural desistance.

In a Dutch study that included seventy adolescents who took puberty blockers, all seventy decided to go on to hormones of the opposite sex (de Vries, et al. 2011). In a follow-up study, the overwhelming majority went on to have sex reassignment surgery by either vaginoplasty for males or hysterectomy with ovariectomy for females (de Vries, et al. 2014). These surgeries resulted in sterilization. This is why puberty blockers, rather than

being a “pause” to consider aspects of mental health, are instead a pathway towards future sterilizing surgeries. The surgeries were consequential in another important way. One person who had a vaginoplasty died of post-surgical complications of necrotizing fasciitis which is a rapidly progressive and very severe infection of the soft tissues beneath the skin and which has a high mortality (Id.).

#### **e. Infertility as a result of Puberty Blockers in GAT**

Dr. Antommara states that “Florida Medicaid provides coverage for the use of puberty blockers to treat central precocious puberty, but now prohibits coverage for the use of puberty blockers to treat gender dysphoria, even though the use of puberty blockers to treat both conditions has comparable risks and is supported by comparable types of evidence” (Antommara decl, p. 24). These statements fail to recognize the very different effects of PB medication in early childhood versus during adolescence.

Giving puberty blockers to a four year old with central precocious puberty will obviously not impair fertility, as the four year old has not yet become fertile. The child will at a later time have the puberty blocker discontinued and then normal pubertal development can proceed. Therefore when they are no longer taking the medication, they will gain natural fertility.

In contrast, puberty blocking medication given to minors in GAT occurs at precisely the time that the child will gain reproductive function. This will stop sperm production in the male and ovulation in the female (if these have already occurred, otherwise the functions will not even begin) which produces the infertile condition. Importantly, so long as the minor continues PB they will remain infertile. Should they continue on to opposite sex hormones as part of GAT then they will remain infertile. There is the additional possibility that cytotoxic effects of high dose opposite sex hormones will damage the immature gonads leading to permanent sterility.

### **3. Opposite Sex Hormones**

The third stage of gender affirmative therapy involves using hormones of the opposite sex at high doses to attempt to create secondary sex characteristics in the person's body.

### a. Testosterone

Testosterone is an anabolic steroid of high potency. It is classified as a Schedule 3 controlled substance by the DEA: "Substances in this schedule have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence" (DEA, 2022). A licensed physician with a valid DEA registration is required to prescribe testosterone.

I prescribe testosterone to men for testosterone deficiency. The state of testosterone deficiency can cause various problems including problems of mood, sexual function, libido, and bone density. Prescription testosterone is given to correct the abnormally low levels and bring them back into balance. The dose of testosterone must be carefully considered and monitored to avoid excess levels in the male as there are a number of serious concerns when prescribing testosterone.

Regarding the potential for abuse, the labeling reads "Testosterone has been subject to abuse, typically at doses higher than recommended for the approved indication...Anabolic androgenic steroid abuse can lead to serious cardiovascular and psychiatric adverse reactions...Abuse and misuse of testosterone are seen in male and female adults and adolescents...There have been reports of misuse by men taking higher doses of legally obtained testosterone than prescribed and continuing testosterone despite adverse events or against medical advice." (Actavis Pharma, 2018)

Adverse events with respect to the nervous system include: "Increased or decreased libido, headache, anxiety, depression, and generalized paresthesia." (Actavis Pharm, 2018)

With regard to ultimate height, "[t]he following adverse reactions have been reported in male and female adolescents: premature closure of bony epiphyses with termination of growth" (Actavis Pharma, Inc., 2018). What this means is that testosterone applied to the adolescent will cause premature closure of the growth plates, stopping further gains in height in the growing individual, and ultimately making the person shorter than they otherwise would have been.

With respect to the cardiovascular system of men using ordinary doses, "Long-term clinical safety trials have not been conducted to assess the cardiovascular outcomes of testosterone

replacement therapy in men” (Actavis Pharma, 2018). No clinical safety trials have been performed for women or adolescent girls to my knowledge.

“There have been postmarketing reports of venous thromboembolic events [blood clots], including deep vein thrombosis (DVT) [blood clot of the extremity such as the leg] and pulmonary embolism (PE) [blood clot of the lung which may be deadly], in patients using testosterone products, such as testosterone cypionate” (Actavis Pharma, 2018).

A very recently published study of adverse drug reactions (ADRs) as part of gender affirming hormone therapies in France states that “[o]ur data show a previously unreported, non-negligible proportion of cases indicating cardiovascular ADRs in transgender men younger than 40 years... In transgender men taking testosterone enanthate, all reported ADRs were cardiovascular events, with pulmonary embolism in 50% of cases” (Yelehe et al., 2022).

There are also serious concerns regarding liver dysfunction: “Prolonged use of high doses of androgens ... has been associated with development of hepatic adenomas [benign tumors], hepatocellular carcinoma [cancer], and peliosis hepatis [generation of blood-filled cavities in the liver that may rupture] —all potentially life-threatening complications” (Actavis Pharma, 2018).

In GAT, what is termed “cross sex hormones” is the use of hormones of the opposite sex to attempt to create secondary sex characteristics. To do so, very high doses of these hormones are administered. When hormone levels climb above normal levels they are termed supraphysiologic.

#### **b. Opposite Sex Hormones - Supraphysiologic Doses of Testosterone for Females**

The female person does produce some smaller amount of testosterone relative to the male. The normal reference range for adult females depending on the lab is about 10 to 50 ng/dL. However, in female disease conditions these levels can be much higher. For example, in polycystic ovarian syndrome levels may range from 50 to 150 ng/dL. PCOS has been associated with insulin resistance (Dunaif, 1989), metabolic syndrome (Apridonidze, 2005) and diabetes (Joham, 2014).

In certain endocrine tumors such as adrenal carcinoma these levels may be substantially higher in the 300 to 1000 ng/dl range. Adrenal carcinoma is a serious medical condition and may be treated by surgery and potent endocrine medications.

Recommendations from the Endocrine Society's clinical guidelines related to GAT are to ultimately raise female levels of testosterone to 320 to 1000 ng/dL<sup>4</sup> which is on the same order as dangerous endocrine tumors for women as described above (Hembree, 2017). A simple calculation shows this level for the adult may be anywhere from 6 to 100 times higher than native female testosterone levels. In doing so they are creating a hormone imbalance known as hyperandrogenism. These extraordinarily high levels of testosterone are associated with multiple risks to the physical and mental health of the patient.

““Studies of transgender males taking testosterone have shown up to a nearly 5-fold increased risk of myocardial infarction relative to females not receiving testosterone” (Laidlaw et al., 2021; Alzahrani et al., 2019). A female can also develop unhealthy, high levels of red blood cells referred to as erythrocytosis. These high red blood cell counts in young women have been shown to be an independent risk factor for cardiovascular disease, coronary heart disease and death due to both (Gagnon, 1994).

Other permanent effects of testosterone therapy involve irreversible changes to the vocal cords. Abnormal amounts of hair growth which may occur on the face, chest, abdomen, back and other areas is known as hirsutism. Should the female eventually regret her decision to take testosterone, this body hair can be very difficult to remove. Male pattern balding of the scalp may also occur. Common sense suggests that changes of voice and hair growth could be psychologically troubling should the patient attempt to reintegrate into society as a female.

Changes to the genitourinary system include polycystic ovaries and atrophy of the lining of the uterus. The breasts have been shown to have an increase in fibrous breast tissue and a decrease in normal glandular tissue (Grynberg et al., 2010). Potential cancer risks from high dose testosterone include ovarian and breast cancer (Hembree, 2017).

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<sup>4</sup> In the Endocrine Society's Guidelines there is no grading of evidence for the rationale of using such high supraphysiologic doses of opposite sex hormones for the female or male. There seems to be an underlying assumption that because the person believes to be the opposite sex then they acquire the sex specific laboratory ranges of the opposite sex. "The root cause of this flaw in thinking about diagnostic ranges was exemplified in a response letter by Rosenthal et al claiming that gender identity determines the ideal physiologic range of cross-sex hormone levels (5). Thus, a psychological construct, the 'gender identity', is imagined to affect physical reality and change a person's sex-specific laboratory reference ranges. This is clearly not the case, otherwise there would be no serious complications of high-dose androgen treatment in transgender males" (Laidlaw et al., 2021).

According to research regarding testosterone abuse, high doses of testosterone have been shown to predispose individuals towards mood disorders, psychosis, and psychiatric disorders. The "most prominent psychiatric features associated with AAS [anabolic androgenic steroids, i.e. testosterone] abuse are manic-like presentations defined by irritability, aggressiveness, euphoria, grandiose beliefs, hyperactivity, and reckless or dangerous behavior. Other psychiatric presentations include the development of acute psychoses, exacerbation of tics and depression, and the development of acute confusional/delirious states" (Hall, 2005). Moreover, "[s]tudies... of medium steroid use (between 300 and 1000 mg/week of any AAS) and high use (more than 1000 mg/week of any AAS) have demonstrated that 23% of subjects using these doses of steroids met the DSM-III-R criteria for a major mood syndrome (mania, hypomania, and major depression) and that 3.4% — 12% developed psychotic symptoms" (Hall, 2005).

### **c. Estrogen**

Estrogen is the primary sex hormone of the female. Prescription estrogen may be used if a woman has low estrogen levels due to premature failure of her ovaries. Estrogen is prescribed to bring these levels back into a normal range for the patient's age. Another labeled use of estrogen is to treat menopausal symptoms.

### **d. Opposite Sex Hormones - Supraphysiologic Estrogen for Males**

For the male, estrogen is being used at supraphysiologic doses. The high doses are used in an attempt to primarily affect an increase of male breast tissue development known as gynecomastia. Gynecomastia is the abnormal growth of breast tissue in the male. The occurrence of gynecomastia in the male is sometimes corrected by medication or more commonly by surgery if needed. Other changes of secondary sex characteristics may develop such as softening of the skin and changes in fat deposition and muscle development.

The doses of estrogen given to males for GAT are high and may vary from two to eight or more times higher than normal adult male levels. This produces the endocrine condition called hyperestrogenemia. Long-term consequences include increased risk of myocardial infarction and death due to cardiovascular disease (Irwig, 2018). Also "[t]here is strong



evidence that estrogen therapy for trans women increases their risk for venous thromboembolism<sup>5</sup> over 5 fold" (Irwig, 2018).

Breast cancer is a relatively uncommon problem of the male. However the risk of a male developing breast cancer has been shown to be 46 times higher with high dose estrogen (Christel et al., 2019).

It is clear that supraphysiologic doses of either testosterone for the female or estrogen for the male can have detrimental health consequences. This is only now being borne out in the literature for adults. However as more children and adolescents are put on these medications one would expect these consequences to become more frequent and to occur earlier in their lives.

#### **4. Surgeries**

The fourth stage of gender affirmative therapy is surgical alterations of the body of various kinds in an attempt to somehow mimic features of the opposite sex.

Individual surgical procedures can be a complex topic. It is helpful to first step back and consider conceptually what any surgery can and cannot accomplish.

In its basic form surgery is subtractive. In other words, a portion of tissue, an organ or organs are removed in order to restore health. For example, a diseased gallbladder may be surgically removed to help the patient get back to wellness. An infected appendix may be surgically removed to prevent worsening infection or even death. In both of these cases an unhealthy body part is surgically removed in order to restore health.

In some cases a diseased tissue or organ is removed so that a foreign replacement part may be substituted for an unhealthy organ or tissue. For example, a diseased heart valve may be replaced with a pig valve or a prosthetic heart valve. Another example is a failed liver may be replaced by liver transplant.

Though modern surgical techniques and procedures are astounding, there are very noteworthy limitations. Importantly, surgery cannot de novo create new organs. If a person's kidneys fail, the surgeon has no scientific method for creating a new set of kidneys

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<sup>5</sup> Venous thromboembolism is a blood clot that develops in a deep vein and "can cause serious illness, disability, and in some cases, death" (CDC, 2022).

that can be implanted or grown within the patient. This conceptual background is helpful when considering various gender affirming surgeries.

There are a variety of gender affirming surgeries for females. These may include mastectomies, metoidioplasty, and phalloplasty.

#### **a. Mastectomy**

Mastectomies are the surgical removal of the breasts. The procedure is used in GAT in an attempt to make the chest appear more masculine. The surgery results in a permanent loss of the ability to breastfeed and significant scarring of 7 to 10 inches. The scars are prone to widening and thickening due to the stresses of breathing and arm movement. Other potential complications include the loss of normal nipple sensation and difficulties with wound healing (American Cancer Society, 2022).

It is important to note that this operation cannot be reversed. The female will never regain healthy breasts capable of producing milk to feed a child (Mayo Clinic, Top Surgery, 2022).

Another important consideration is that compared to the removal of an unhealthy gallbladder or appendix, in the case of gender dysphoria the breasts are perfectly healthy and there is no organic disease process such as a cancer warranting their removal. The future woman who later desists is left with regret about what happened to her at an age before she could provide true informed consent. Functioning breasts cannot be created by a surgeon and restored to a patient in case of regret. She is left with permanent injury and loss of function with respect to her breasts.

#### **b. GAT Surgeries on the Male**

GAT surgeries for the male include removal of the testicles alone to permanently lower testosterone levels. This is by nature a sterilizing procedure. Further surgeries may be done in an attempt to create a pseudo-vagina which is called vaginoplasty. In this procedure, the penis is surgically opened and the erectile tissue is removed. The skin is then closed and inverted into a newly created cavity in order to simulate a vagina. A dilator must be placed in the new cavity for some time so that it does not naturally close.

Potential surgical complications may include urethral strictures, infection, prolapse, fistulas and injury to the sensory nerves with partial or complete loss of erotic sensation (Mayo Clinic, Feminizing Surgery, 2022).

### **c. GAT Surgeries of the Female Pelvis and Genitalia**

Other types of surgery for females include those of the genitalia and reproductive tract. For example, the ovaries, uterus, fallopian tubes, cervix and the vagina may be surgically removed. Removal of the ovaries results in sterilization.

Importantly, removing female body parts does not produce a male. Rather, the female has had sex specific organs permanently destroyed with no hope of replacement, while remaining biologically female.

There have also been attempts to create a pseudo-penis. This procedure is known as phalloplasty. It is not possible to de novo create a new human penis. Instead, a roll of skin and subcutaneous tissue is removed from one area of the body, say the thigh or the forearm, and transplanted to the pelvis. An attempt is made to extend the urethra or urinary tract for urination through the structure. This transplanted tissue lacks the structures inherent in the male penis which allow for erection, therefore erectile devices such as rods or inflatable devices are placed within the tube of transplanted tissue in order to simulate erection (Hembree, 2017). The labia may also be expanded to create a simulated scrotum containing prosthetic objects to provide the appearance of testicles.

Complications may include urinary stricture, problems with blood supply to the transplanted roll of tissue, large scarring to the forearm or thigh, infections including peritonitis, and possible injury to the sensory nerve of the clitoris (Mayo Clinic, Masculinizing Surgery, 2022). A recent systematic review and meta-analysis of 1731 patients who underwent phalloplasty found very high rates of complications (76.5%) including a urethral fistula rate of 34.1% and urethral stricture rate of 25.4% (Wang, 2022).

## **H. Life Threatening Physical Medical Conditions Versus Suicidal Ideation**

Any child or adolescent who has suicidal ideation or has attempted suicide should receive immediate, appropriate psychiatric care. Psychologists and psychiatrists are trained in the recognition and treatment of suicidal ideation and prevention of suicide. A child or adolescent with gender dysphoria who also has suicidal ideation should not be treated any

differently. They require compassionate care and a full psychological evaluation of comorbidities such as depression, anxiety, and self-harming behaviors.

However, suicidal ideation or attempts are categorically different than other life-threatening situations, such as a rapidly expanding brain tumor or a severe infection. In these situations, a medication or a surgery is used to stop the progression of an organic physical condition. In contrast, the danger to the self with suicidal ideation relates to a condition of the mind.

Gender affirmative therapy does not treat any life-threatening physical condition. In fact, it creates a number of new medical conditions as described above. It is also not an appropriate treatment for suicidal ideation. Neither puberty blocking medications, nor testosterone, nor estrogen have been FDA approved for suicide prevention. Moreover, as noted above, the hormone imbalances generated by the medications used in GAT actually increase psychological conditions that lead to suicidal ideation and completed suicide.

### **I. Informed Consent**

Any person who is to take a medication, undergo a surgical procedure, or have a psychological intervention should understand the risks and benefits before proceeding. A discussion of these risks and benefits should be provided by medical professionals and then the person of sufficient intellectual capacity and maturity can consent to the treatment.

Naturally difficulties arise when a minor is involved in the process of medical decision-making. Their intellect, emotions, and judgment are not fully developed and they are not capable of fully appreciating permanent, life altering changes such as described above. Therefore, they cannot provide informed consent. They may sometimes "assent" to a procedure or medication with a parent or guardian making the final decision.

With respect to GAT, in my opinion, it is not possible for the parent or guardian to make a true informed consent decision for the child because of the poor quality of evidence of benefit, the known risks of harm, and the many unknown long-term risks of harm which could only truly be known after years and decades of gender affirmative therapy. A parent or guardian cannot consent to dubious treatments which result in irreversible changes to their child's body, infertility, sexual dysfunction, and in many cases eventual sterilization.

Because this age group is still undergoing brain development and they are immature with respect to intellect, emotion, judgment, and self-control, in my professional opinion there is a significant chance a young person may later regret the irreversible bodily changes that result from hormones or from removing an organ or organs that will no longer function and cannot be replaced.

I would also note that adolescents are more prone to high-risk behavior and less likely to fathom the risks and consequences of these decisions (Steinberg, 2008).

### **J. The WPATH and The Endocrine Society**

According to their declarations, the experts Dr. Johanna Olson-Kennedy, Dr. Loren Schechter, and Dr. Dan H. Karasic are members of WPATH. Dr. Schechter was "co-lead author of the surgical and postoperative care chapter" for SOC 8 (Schechter decl, p 4). Dr. Karasic was a lead author of the Mental Health chapter for SOC 8 (Karasic decl, p. 3).

WPATH's Standards of Care 7 were produced over a decade ago in 2011. They were prepared within their advocacy organization and are purported to be a "professional consensus about the psychiatric, psychological, medical, and surgical management of gender dysphoria" (WPATH, 2022). However, the "professional consensus" exists only within the confines of its organization. Furthermore, their Standards of Care 7, unlike the Endocrine Society's guidelines, do not have a grading system for either the strength of their recommendations or the quality of the evidence presented.

While the Endocrine Society has issued "Endocrine Treatment of Gender-Dysphoric / Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," these are only "guidelines." The Endocrine Society's guidelines (ESG) specifically state that their "guidelines cannot guarantee any specific outcome, nor do they establish a standard of care" (Hembree et al, 2017, p. 3895).

With respect to the makeup of authors of the ESG, nine out of ten authors were members of WPATH or worked on WPATH's scientific committees. Seven of those nine had at some time been in WPATH leadership including the WPATH presidency and board of directors (File: WPATH - Endocrine Society 2017 guidelines.pdf).

In the Endocrine Society's guidelines, the quality of evidence for the treatment of adolescents is rated "very low-quality evidence" and "low quality evidence". "The quality

of evidence for [puberty blocking agents] is noted to be low. In fact, all of the evidence in the guidelines with regard to treating children/adolescents by [gender affirmative therapy] is low to very low because of the absence of proper studies” (Laidlaw et al., 2019).

Unlike some other recommendations for adolescent GAT, the Endocrine Society’s guidelines do not include any grading of the quality of evidence specifically for their justification of laboratory ranges of testosterone or estrogen or for adolescent mastectomy or other surgeries.

Endocrinologists W. Malone and P. Hruz and colleagues have written critically of the Endocrine Society’s (ES) guidelines: “Unlike standards of care, which should be authoritative, unbiased consensus positions designed to produce optimal outcomes, practice guidelines are suggestions or recommendations to improve care that, depending on their sponsor, may be biased. In addition, the ES claim of effectiveness of these interventions is at odds with several systematic reviews, including a recent Cochrane review of evidence (5), and a now corrected population-based study that found no evidence that hormones or surgery improve long-term psychological well-being (6). Lastly, the claim of relative safety of these interventions ignores the growing body of evidence of adverse effects on bone growth, cardiovascular health, and fertility, as well as transition regret” (Malone et al., 2021).

In June of 2022, the Endocrine Society published "Enhancing the Trustworthiness of the Endocrine Society’s Clinical Practice Guidelines" (McCartney et al., 2022). They wrote "In an effort to enhance the trustworthiness of its clinical practice guidelines, the Endocrine Society has recently adopted new policies and more rigorous methodologies for its guideline program." (Id.) They relate that in 2019, the ECRI Guidelines Trust "asked the Society for permission to include its guidelines in the ECRI Guidelines Trust database". However, after an evaluation by ECRI, the guideline related to osteoporosis "was the only guideline for which all recommendations were based on verifiable systematic evidence review with explicit descriptions of search strategy, study selection, and evidence summaries" (Id.). Therefore we can conclude that with regard to the recommendations from the ESG 2017 on Gender Dysphoria/Gender Incongruence not all recommendations were "based on verifiable systematic evidence review with explicit descriptions of search strategy, study selection, and evidence summaries". Furthermore, these ESG 2017 were highly subject to conflicts of interest. As related earlier, nine out of the 10 authors were members or worked on the scientific committees of the advocacy group WPATH. Additionally, the ESG 2017 document was endorsed by WPATH. The "Enhancing

Trustworthiness" article recommends the opposite composition of authors for guidelines: "A majority (>50%) of non-Chair GDP members must be free of relevant C/DOI [conflict/duality of interest]" (McCartney et al., 2022).

WPATH Standards of Care 8 (SOC 8) were just published Sep. 6, 2022 (Coleman et al., 2022) . In a correction to the SOC 8, all guidelines for minimum age of surgery were removed, meaning a minor of any age could be referred for any of the GAT surgeries listed previously (Correction IJTH, 2022). All guidelines for minimum age of opposite sex hormones were also removed.

The correction reads: "On page S258, the following text was removed:

'The following are suggested minimal ages when considering the factors unique to the adolescent treatment time frame for gender-affirming medical and surgical treatment for adolescents, who fulfil all of the other criteria listed above.

- Hormonal treatment: 14 years
- Chest masculinization: 15 years
- Breast augmentation, Facial Surgery: 16 years
- Metoidioplasty, Orchiectomy, Vaginoplasty,
- Hysterectomy, Fronto-orbital remodeling: 17 years
- Phalloplasty: 18 years'" (WPATH SOC 8 Correction, p. S261).

Of great concern is that the minimum age recommendations were retracted, it appears, in contradiction to the recommendation of their own expert consensus:

"On page S66, the following text was removed:

'Age recommendations for irreversible surgical procedures were determined by a review of existing literature and the expert consensus of mental health providers, medical providers, and surgeons highly experienced in providing care to TGD adolescents.'" (WPATH SOC 8 Correction, p. S260).

Additionally, a chapter regarding eunuchs was inserted into SOC 8 that gives recommendations for how to induce hypogonadism in men who have the eunuch "gender identity"<sup>6</sup> by either orchiectomy [testicle removal] or chemical castration such as with GnRH analogues (Coleman et al., 2022)<sup>7</sup>.

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<sup>6</sup> The notion that there is a "eunuch gender identity" further invalidates the gender identity as a serious biological property of human beings: "Many eunuch individuals see their status as eunuch as their distinct gender identity with no other gender or transgender affiliation" (Coleman et al., 2022, p. S88).

<sup>7</sup> "Treatment options for eunuchs to consider include:

The SOC8 also used an aberrant form of the GRADE approach for systematic reviews that removed the grading of quality of evidence (which should be categorized as very low, low, moderate, and high quality).<sup>8</sup> Instead any recommendation of "recommend" is automatically assigned as high quality of evidence. SOC 8 also failed to provide evidence profile tables which should include "an explicit judgment of each factor that determines the quality of evidence for each outcome" (Guyatt et al., 2021).

Such a modification of GRADE is explicitly recommended against in the referenced GRADE document<sup>9</sup> and in so doing, in my opinion, invalidates all of the SOC 8 recommendations as being evidence-based.

For at least the reasons above, in my professional opinion WPATH SOC 8 represents a grave and immediate danger to minors, young adults, and adults and should not be followed by any physician, mental health care provider, or other medical professional.

### **K. Harms of off-label treatments in GAT**

Dr. Antommaria makes a faulty comparison between migraine headaches and gender dysphoria (Antommaria decl, p. 7). First, migraine headaches are a neurological condition with a potential vascular component and not a condition of the mind, nor found as a psychological diagnosis in the DSM-5. Second the treatment of migraine headaches

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- Hormone suppression to explore the effects of androgen deficiency for eunuch individuals wishing to become asexual, nonsexual, or androgynous;
  - Orchiectomy [testicle removal] to stop testicular production of testosterone;
  - Orchiectomy with or without penectomy to alter their body to match their self-image;
  - Orchiectomy followed by hormone replacement with testosterone or estrogen. " (Id.)

<sup>8</sup> From SOC 8 "The [recommendation] statements were classified as:

- Strong recommendations ("we recommend") are for those interventions/therapy/strategies where:
  - the evidence is of high quality" (Id., p. S250).

<sup>9</sup>From the GRADE guidelines: "Some organizations have used modified versions of the GRADE approach. We recommend against such modifications because the elements of the GRADE process are interlinked because modifications may confuse some users of evidence summaries and guidelines, and because such changes compromise the goal of a single system with which clinicians, policy makers, and patients can become familiar" (Guyatt et al., 2011).



with a medication such as sumatriptan or similar are labeled indications for the condition unlike GnRH agonists and opposite sex hormones in GAT (FDA.gov sumatriptan). Third, the side effects of medications like sumatriptan do not alter or block normal human development such as the case with puberty blocking medication, or cause permanent alterations of the body such as with sex hormones, or lead to the permanent loss of healthy functioning organs such as occurs with surgeries which alter sex as a part of GAT.

Dr. Olson-Kennedy also draws a faulty comparison when she compares the off-label use of antibiotics or anti-histamines to blocking normal puberty, administering high-dose opposite sex hormones, or the permanent removal of healthy organs as part of GAT (Olson-Kennedy decl, p. 38 ). The health consequences are categorically different and the lifelong potential for permanent injury are extremely high in GAT.

### **L. The Lack of Evidence of Effectiveness of GAT**

There is much additional evidence that questions the long-term benefits of opposite sex hormones and gender reassignment surgery and in fact suggests serious harms.

#### **1. Sweden's Long-term study of 30 years of data by Dhejne**

The most comprehensive study of its kind is from Sweden in 2011. The authors examined data over a 30-year time period (Dhejne, 2011). The Dhejne team made extensive use of numerous Swedish database registries and examined data from 324 patients in Sweden over 30 years who had taken opposite sex hormones and had undergone sex reassignment surgery. They used population controls matched by birth year, birth sex, and reassigned sex. When followed out beyond ten years, the sex-reassigned group had nineteen times the rate of completed suicides and nearly three times the rate of all-cause mortality and inpatient psychiatric care compared to the general population of Sweden.

#### **2. The Branstrom and Pachankis Retraction**

Other published studies of GAT have been shown to have serious errors. For example, a major correction was issued by the American Journal of Psychiatry. The authors and editors of a 2020 study, titled "Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study" (Bränström study, 2020) retracted their original primary conclusion. Letters to the editor by twelve authors

including myself led to a reanalysis of the data and a corrected conclusion stating that in fact the data showed no improvement in mental health for transgender identified individuals after surgical treatment nor was there improvement with opposite sex hormones (“Correction”, 2020; Van Mol et al., 2020).

The initial reports of this study claimed that the authors found treatment benefits with surgery, and this was shared widely in the media. For example, ABC News posted an article titled "Transgender surgery linked with better long-term mental health, study shows" (Weitzer, 2019). An NBC news/Reuters headline reads "Sex-reassignment surgery yields long-term mental health benefits, study finds" (Reuters, 2019).

However, after twelve authors from around the world including our team investigated the study in detail, a number of serious errors were exposed leading to a retraction (Kalin, 2020; Anckarsäter et al., 2020).

In our letter to the editor which I co-wrote with former Chairman of Psychiatry at Johns Hopkins Medical School, Paul McHugh, MD, we noted key missing evidence in the original Branstrom report when compared to the previous body of knowledge yielded from the Swedish Dhejne study. We wrote that “[t]he study supports only weak conclusions about psychiatric medication usage and nothing decisive about suicidality. In overlooking so much available data, this study lacks the evidence to support its pro gender-affirmation surgery conclusion” (Van Mol, Laidlaw, et al., 2020).

In another letter, Professor Mikael Landen writes that “the authors miss the one conclusion that can be drawn: that the perioperative transition period seems to be associated with high risk for suicide attempt. Future research should use properly designed observational studies to answer the important question as to whether gender-affirming treatment affects psychiatric outcomes” (Landen, 2020).

In another letter to the editor, psychiatrist David Curtis noted that “[t]he study confirms the strong association between psychiatric morbidity and the experience of incongruity between gender identity and biological sex. However, the Branstrom study does not demonstrate that either hormonal treatment or surgery has any effect on this morbidity. It seems that the main message of this article is that the incidence of mental health problems and suicide attempts is especially high in the year after the completion of gender-affirming surgery” (Curtis, 2020).

In yet another critical letter, Dr. Agnes Wold states that "[w]hether these factors involve a causal relationship (i.e., that surgery actually worsens the poor mental health in individuals with gender dysphoria) cannot be determined from such a study. Nevertheless, the data presented in the article do not support the conclusion that such surgery is beneficial to mental health in individuals with gender dysphoria" (Wold, 2020).

### **3. Flawed studies based on the problematic 2015 US Transgender Survey**

A 2021 study by Almazan and Keurghlian attempted to address mental health outcomes in relation to surgery as a part of GAT (Almazan & Keurghlian, 2021). This was not a randomized controlled study nor a prospective observational study. Rather the study relied upon the 2015 US Transgender Survey (USTS), which has been severely criticized for its serious limitations and weaknesses.

D'Angelo et al. have written about the 2015 USTS survey as part of the criticism of another flawed study in the journal *Pediatrics* by Jack Turban in 2020 titled "Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation" (Turban, 2020). They write in their critique of the USTS that it is "a convenience sampling, a methodology which generates low-quality, unreliable data." (Bornstein, Jager, & Putnick, 2013). Specifically, the participants were recruited through transgender advocacy organizations and subjects were asked to 'pledge' to promote the survey among friends and family. This recruiting method yielded a large but highly skewed sample...Their analysis is compromised by serious methodological flaws, including the use of a biased data sample, reliance on survey questions with poor validity, and the omission of a key control variable, namely subjects' baseline mental health status." They also state that "[s]igmatizing non-'affirmative' psychotherapy for GD [gender dysphoria] as 'conversion' will reduce access to treatment alternatives for patients seeking non-biomedical solutions to their distress" (D'Angelo et al., 2021).

### **4. Mastectomy Surgery for Minors**

Any serious look at long-term effects at surgical treatment would follow subjects out at least ten years. For example, an article was published recently examining patients who had mild calcium disorders due to a gland called the parathyroid. They compared a group of patients who had surgical removal of the parathyroid to a control group who had not. They examined data ten years after surgery was completed and concluded that parathyroid

surgery in this group "did not appear to reduce morbidity or mortality" in that patient group (Pretorius, 2022).

To my knowledge there exists no comparable studies of minors with gender dysphoria comparing those who had mastectomy surgery to a control group who had not. There are also no known studies of minors followed for 10 years or more to determine the long-term risks and benefits of mastectomy for gender dysphoria.

Good quality studies specifically showing that mastectomy surgery is safe, effective, and optimal for treating minors with gender dysphoria do not exist. For example, there is a study titled "Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults Comparisons of Nonsurgical and Postsurgical Cohorts" (Olson-Kennedy, 2018). The study authors conclude that "[c]hest dysphoria was high among presurgical transmasculine youth, and surgical intervention positively affected both minors and young adults." However, there are a number of problems with this study. First, the term "chest dysphoria" is a creation of the study authors and is not found as a diagnosis or even referenced in the DSM-5. Second the "chest dysphoria scale" is a measuring tool created by the authors, but which the authors state "is not yet validated." (*Id.*, p. 435) Third, the mastectomies were performed on girls as young as 13 and 14 years old and who thereby lacked the maturity and capacity of good judgment for truly informed consent for this life altering procedure. For this reason, in my professional opinion, the research and surgeries performed were flawed and unethical.

There exists another poorly designed study which suffers from similar methodological and ethical problems as the Olson-Kennedy study. A 2021 study published in *Pediatrics* examined females aged 13-21 recruited from a gender clinic. Thirty young females had mastectomy procedures and sixteen had not. The average age at surgery was 16.4 years (Mehring, 2021). The follow up time after surgery was only 19 months and no data is provided or analyzed about key psychiatric information such as comorbid psychological illnesses, self-harming behaviors, psychiatric hospitalizations, psychiatric medication use, or suicide attempts.

Information returned from the study surveys were all qualitative and included responses such as "[My chest dysphoria] made me feel like shit, honestly. It made me suicidal. I would have breakdowns". Another respondent stated, "I've been suicidal quite a few times over just looking at myself in the mirror and seeing [my chest]. That's not something that I should have been born with" (Mehring, 2021). The omission of psychiatric data is a

major flaw in the study and also irresponsible given the obviously dangerous psychological states that some of these young people were in.

Since such a high proportion of subjects were using testosterone (83%), some of the responses could be attributed to adverse effects of testosterone. For example, as related earlier, high dose testosterone can manifest in irritability and aggressiveness. One study subject responded, "I get tingly and stuff and it kind of makes me want to punch something" (Mehringer, 2022).

The testosterone labeling also indicates nausea and depression as adverse reactions which are described by another study subject "There's a feeling of hopelessness, of desperation, of—almost makes me feel physically sick" (Actavis Pharma, Inc., 2018; Mehringer, 2022).

The study appears to have been designed, at least in part, to justify insurance companies paying for mastectomy procedure for minors with GD, even though they have provided no long-term statistical evidence of benefit: "These findings...underscore the importance of insurance coverage not being restricted by age" (Mehrniger, 2021). This also appears to be part of the aim of the flawed Olson-Kennedy study which stated "changes in clinical practice and in insurance plans' requirements for youth with gender dysphoria who are seeking surgery seem essential" (Olson-Kennedy, 2018). So these two studies, rather than being a thorough examination of the psychological and physical risks and benefits of mastectomy surgery over the long-term appear instead to exist, at least in part, to validate the need for insurance companies to insure the costs of these dubious procedures for minors.

## **5. Centers for Medicare and Medicaid Services**

The Centers for Medicare and Medicaid Services ("CMS") has found "inconclusive" clinical evidence regarding gender reassignment surgery. Specifically, the CMS Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) (June 19, 2019) states: "The Centers for Medicare & Medicaid Services (CMS) is not issuing a National Coverage Determination (NCD) at this time on gender reassignment surgery for Medicare beneficiaries with gender dysphoria because the clinical evidence is inconclusive for the Medicare population."

Dr. Schechter states: "The result of CMS's review of the evidence is not applicable to other population groups" (Schechter decl, p. 39). However it does not make the converse true as

Dr. Schecter seems to imply. In other words, the CMS review does not therefore mean that there is conclusive evidence of benefit and lack of harm for the under 65 population. On the contrary, evidence of benefit is lacking and the risks and harms due to GAT are very high as I have described.

## **6. Nations and States Question and Reverse Course on GAT**

Also noteworthy is that other nations are questioning and reversing course regarding gender affirmative therapy. For example in the *Bell v. Tavistock* Judgment in the UK, regarding puberty blockers in GAT, they concluded that "there is real uncertainty over the short and long-term consequences of the treatment with very limited evidence as to its efficacy, or indeed quite what it is seeking to achieve. This means it is, in our view, properly described as experimental treatment" (*Bell v. Tavistock* Judgment, 2020).

The case was appealed and although the medical decision making was returned to clinicians (rather than the courts), it was noted that great pains should be taken to ensure that the child and parents are properly informed before embarking on such treatments. In its conclusion the appeals court stated that "[c]linicians will inevitably take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed by the advantages and disadvantages of the proposed course of treatment and in the light of evolving research and understanding of the implications and long-term consequences of such treatment. Great care is needed to ensure that the necessary consents are properly obtained" (*Bell v. Tavistock* Appeal, Judgment, 2021).

In the bulletin of the Royal College of Psychiatrists in 2021, in a reevaluation of the evidence, Griffin and co-authors write, "As there is evidence that many psychiatric disorders persist despite positive affirmation and medical transition, it is puzzling why transition would come to be seen as a key goal rather than other outcomes, such as improved quality of life and reduced morbidity. When the phenomena related to identity disorders and the evidence base are uncertain, it might be wiser for the profession to admit the uncertainties. Taking a supportive, exploratory approach with gender-questioning patients should not be considered conversion therapy" (Griffin et al., 2021).

In 2020, Finland recognized that "[r]esearch data on the treatment of dysphoria due to gender identity conflicts in minors is limited," and recommended prioritizing psychotherapy for gender dysphoria and mental health comorbidities over medical gender

affirmation (Council for Choices in Healthcare in Finland, 2020). Additionally, “[s]urgical treatments are not part of the treatment methods for dysphoria caused by gender-related conflicts in minors”.

In 2021, Sweden’s largest adolescent gender clinic announced that it would no longer prescribe puberty blockers or cross-sex hormones to youth under 18 years outside clinical trials (SEGM, 2021). "In December 2019, the SBU (Swedish Agency for Health Technology Assessment and Assessment of Social Services) published an overview of the knowledge base which showed a lack of evidence for both the long-term consequences of the treatments, and the reasons for the large influx of patients in recent years. These treatments are potentially fraught with extensive and irreversible adverse consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis. This makes it challenging to assess the risk / benefit for the individual patient, and even more challenging for the minors or their guardians to be in a position of an informed stance regarding these treatments" (Gauffen and Norgren, 2021).

Dr Hilary Cass "was appointed by NHS England and NHS Improvement to chair the Independent Review of Gender Identity Services for children and young people in late 2020" (The Cass Review website, 2022). In her interim report dated February 2022, it states that "[e]vidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally" (Cass, 2022).

### **M. Assessment of the patient with gender dysphoria**

In light of the very serious medical concerns and potential harms of gender affirmative therapy, there are several criteria that I believe would be important to fulfill before applying the GAT model to a patient.

1. Minors should be evaluated to determine if they will follow the natural pattern of desistance which 50 to 98% of pediatric age children will follow<sup>10</sup>.
2. Patients, parents and guardians should be made aware of other options for treatment of gender dysphoria including active psychosocial treatment or watching and waiting with support in order to help with natural desistance.

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<sup>10</sup> From the DSM-5: "Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary...In natal males, persistence has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%" (American Psychiatric Association, 2013).

3. The patient should be provided an assessment by a qualified psychologist or psychiatrist who does not follow the WPATH GAT model. If underlying psychological conditions are diagnosed then these should be adequately evaluated and treated before proceeding to hormones and surgery.

4. If a medicalized approach with hormones such as testosterone or medications to stop menstruation is being considered then a clear description of the risks and benefits needs to be conveyed to the patient and if a minor also the parent or guardian. It needs to be verified that they fully understand these risks.

5. If surgical procedures such as mastectomy, hysterectomy, ovariectomy, orchiectomy, or vaginoplasty are being considered then clear descriptions of the risks and benefits need to be conveyed to the patient, and if a minor, the parent or guardian.

However, even if a minor and their parents or guardian are made fully aware of the risks and benefits of hormones and surgeries, in my opinion, the minor does not have adequate maturity and judgment to make permanent changes to their body that may result in infertility/sterility and the permanent loss of organs such as breasts whose functions will not be fully utilized (such as breastfeeding) until adulthood.

## II. Medical Concerns Regarding Plaintiffs

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### III. Conclusion

The gender affirmative therapy model suffers from serious deficiencies in logic and lacks scientific foundation. The deep error hidden in this model is that one cannot in fact change sex. One cannot acquire the deep characteristics of biological sex in order to gain the complete sexual and reproductive functions of the opposite sex. This is not technologically possible.

Children and adolescents are of such immature minds that they are likely to believe that it is possible. In fact they may come to believe that their inherent, biologically necessary puberty is "terrifying" or needs to be stopped. Social transition serves to convince the child or adolescent that they can be the opposite sex. Puberty blockers sustain this state of mind by retaining a childlike state with respect to the genitalia and body habitus. High dose opposite sex hormones then cause medical conditions such as hirsutism and irreversible damage to the vocal cords in females and gynecomastia in males. These conditions serve to convince the young person that they are going through puberty of the opposite sex when in fact they are not developing sexually and are infertile.

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<sup>15</sup> There are serious concerns regarding liver dysfunction with testosterone: "Prolonged use of high doses of androgens ... has been associated with development of hepatic adenomas [benign tumors], hepatocellular carcinoma [cancer], and peliosis hepatis [generation of blood-filled cavities in the liver that may rupture] —all potentially life-threatening complications" (Actavis Pharma, 2018).

There are known risks for both adults and minors, some of which I have described above, including cardiovascular disease, cancer, deficiencies in ultimate bone density, harms to sexual function, infertility, and for some permanent sterility. The child or adolescent cannot consent to these harms when they are not mature enough to fully comprehend what they mean. Long-term studies regarding the treatment effects specifically for minors with hormones and surgeries, using randomized controlled studies or even proper observational studies do not exist. The two adult plaintiffs and the two plaintiffs' children have comorbidities which make GAT particularly dangerous.

WPATH's newly released SOC 8 represents a grave and immediate danger to minors, young adults, and adults and should not be followed by any physician, mental health care provider, or other medical professional.

For the reasons set forth above, in my professional opinion as an endocrinologist, no child or adolescent should receive puberty blockers to block normal puberty, nor should they receive supraphysiologic doses of opposite sex hormones to attempt to alter secondary sex characteristics, nor should they have surgeries to remove or alter the breasts, genitalia or reproductive tracts as part of GAT. The child cannot consent or assent to these procedures. The parent or guardian also cannot consent to the life altering changes resulting from GAT. There exists insufficient evidence of benefit for adults, but serious concerns for risk of harm.

Finally, the June 2022 AHCA GAPMS report states: "Following a review of available literature, clinical guidelines, and coverage by other insurers and nations, Florida Medicaid has determined that the research supporting sex reassignment treatment is insufficient to demonstrate efficacy and safety" (FL Medicaid GAPMS, 2022). I strongly agree with that statement.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 2nd day of October, 2022.

//s//Michael K. Laidlaw, MD  
Michael K. Laidlaw, MD



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EXHIBIT "A"

**Michael K. Laidlaw, M.D.**  
Endocrinology, Diabetes, and Metabolism  
5180 Grove St.  
Rocklin, CA 95677  
Office: (916) 315-9100  
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### **EMPLOYMENT**

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2006-Present Michael K Laidlaw, MD Inc. Private Practice – Endocrinology, Diabetes, and Metabolism. Rocklin, CA

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### **EDUCATION**

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2004-2006 Endocrinology and Metabolism Fellowship - Los Angeles County/University of Southern California Keck School of Medicine  
2001-2004 Internal Medicine Residency - Los Angeles County/University of Southern California Keck School of Medicine  
1997-2001 University of Southern California Keck School of Medicine  
Doctor of Medicine Degree May 2001  
1990-1997 San Jose State University  
Bachelor of Science Degree in Biology with a concentration in Molecular Biology, Cum Laude

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### **LICENSURE**

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California Medical License – Physician and Surgeon: # A81060: Nov 6, 2002. Exp 5/31/2024.

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### **PROFESSIONAL AFFILIATIONS**

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Endocrine Society 2006-2022  
American Board of Internal Medicine - Endocrinology, Diabetes, and Metabolism – 2006  
American Board of Internal Medicine - Internal Medicine - 2005  
National Board of Physicians and Surgeons - Endocrinology, Diabetes, & Metabolism 2018-2024  
National Board of Physicians and Surgeons - Internal Medicine 2018-2024

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### **HONORS AND RECOGNITION**

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2010 Endocrine Society Harold Vigersky Practicing Physician Travel Award  
2004-2005 Vice President - Joint Council of Interns and Residents  
2002-2004 Council Member – Joint Council of Interns and Residents  
1996, 1997 Dean’s Scholar, San Jose State University  
1995 Golden Key National Honor Society

- 2021 Publication – Michael K Laidlaw, Andre Van Mol, Quentin Van Meter, Jeffrey E Hansen. Letter to the Editor from M Laidlaw et al.: “Erythrocytosis in a Large Cohort of Trans Men Using Testosterone: A Long-Term Follow-Up Study on Prevalence, Determinants, and Exposure Years.” The Journal of Clinical Endocrinology & Metabolism, Volume 106, Issue 12, December 2021, Pages e5275–e5276, <https://doi.org/10.1210/clinem/dgab514>
- 2020 Publication – Van Mol A, Laidlaw MK, Grossman M, McHugh P. "Correction: Transgender Surgery Provides No Mental Health Benefit." Public Discourse, 13 Sep 2020. <https://www.thepublicdiscourse.com/2020/09/71296/>
- 2020 Publication – VanMol A, Laidlaw MK, Grossman M, McHugh P. "Gender-affirmation surgery conclusion lacks evidence (letter)". Am J Psychiatry 2020; 177:765–766.
- 2020 Publication – Laidlaw MK. "The Pediatric Endocrine Society’s Statement on Puberty Blockers Isn’t Just Deceptive. It’s Dangerous." Public Discourse. 13 Jan 2020. <https://www.thepublicdiscourse.com/2020/01/59422/>
- 2019 Speech to the U.K. House of Lords – Laidlaw MK. “Medical Harms Associated with the Hormonal and Surgical Therapy of Child and Adolescent Gender Dysphoria”. Parliament, London, U.K. 15 May 2019.
- 2019 Publication – Laidlaw MK, Cretella M, Donovan K. "The Right to Best Care for Children Does Not Include the Right to Medical Transition". The American Journal of Bioethics. Volume 19. Published online 20 Feb 2019. 75-77. <https://doi.org/10.1080/15265161.2018.1557288>
- 2018 Publication – Laidlaw MK, Van Meter QL, Hruz PW, Van Mol A, Malone WJ. Letter to the Editor: “Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline.” The Journal of Clinical Endocrinology & Metabolism, Volume 104, Issue 3, 1 March 2019, Pages 686–687, <https://doi.org/10.1210/jc.2018-01925> (first published on-line 11/2018)
- 2018 Publication – Laidlaw MK. "The Gender Identity Phantom". [gdworkinggroup.org](http://gdworkinggroup.org), 24 Oct 2018. <http://gdworkinggroup.org/2018/10/24/the-gender-identity-phantom/>
- 2018 Publication – Laidlaw MK. “Gender Dysphoria and Children: An Endocrinologist’s Evaluation of ‘I am Jazz’”. Public Discourse, 5 Apr 2018. <https://www.thepublicdiscourse.com/2018/04/21220/>
- 2013 Abstract – Poster presentation Jun 2013. Endocrine Society Annual Meeting. A 12 Step Program for the Treatment of Type 2 Diabetes and Obesity.
- 2011 Abstract – Poster presentation Nov 2011. Journal of Diabetes Science and Technology. A Video Game Teaching Tool for the Prevention of Type 2 Diabetes and Obesity in Children and Young Adults.
- 2011 Abstract – Journal of Diabetes Science and Technology. A Web-Based Clinical Software Tool to Assist in Meeting Diabetes Guidelines and Documenting Patient Encounters.
- 2008 Abstract - Accepted to Endocrine Society Annual Meeting 2008. Hypercalcemia with an elevated 1,25 dihydroxy-Vitamin D level and low PTH due to granulomatous disease.

- 2005-2006 Clinical Research - University of Southern California – Utility of Thyroid Ultrasound in the Detection of Thyroid Cancer. Study involving the use of color flow/power doppler ultrasound and ultrasound guided biopsy to detect the recurrence of thyroid cancer in patients with total thyroidectomies.
- 2005 Certification - Certification in Diagnostic Thyroid Ultrasound and Biopsy – AACE 2005
- 2003 Certification - Understanding the Fundamentals: Responsibilities and Requirements for the Protection of Human Subjects in Research. University of Southern California. 29 Sep 2003 - 29 Sep 2006
- 2002-2005 Clinical Research - University of Southern California - Determining the Role of Magnesium in Osteoporosis. Study involved collecting and analyzing patient data related to patient characteristics, laboratory results, bone mineral density exams, nutrition analysis, and genetic analysis in order to determine a link between magnesium deficiency and osteoporosis.
- 1996 Research Assistant - San Jose State University - Role of the suprachiasmatic nucleus pacemaker in antelope ground squirrels.
- 1995-1996 Research Assistant - San Jose State University/NASA. Acoustic tolerance test and paste diet study for space shuttle rats.

#### **EXPERT WITNESS WORK AND AMICUS BRIEFS**

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- 2022 Expert Witness Report – Laidlaw MK. C. P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and PATRICIA PRITCHARD, Plaintiff, vs. BLUE CROSS BLUE SHIELD OF ILLINOIS, Defendants. Case No. 3:20-cv-06145-RJB
- 2022 Expert Witness Report – Laidlaw MK. DISTRICT COURT OF TRAVIS COUNTY, TEXAS 459th JUDICIAL DISTRICT. PFLAG, INC., ET AL., Plaintiffs, v. GREG ABBOTT, ET AL., Defendants. NO. D-1-GN-22-002569. 3 July 2022.
- 2022 Expert Witness Report #2 – Laidlaw MK. United States District Court for the District of Arizona. DH and John Doe, Plaintiffs, vs. Jami Snyder, Director of the Arizona Health Care Cost Containment System, in her official capacity, Defendant. Case No. 4:20-cv-00335-SHR. 24 Jun 2022. (Sealed under Protective Order).
- 2022 Expert Witness Report – Laidlaw MK. United States District Court for the Middle District of Alabama Northern Division. REV. PAUL A. EKNES-TUCKER, et al., Plaintiffs, v. KAY IVEY, in her official capacity as Governor of Alabama, et al., Defendants. Civil Action No. 2:22-cv-184-LCB. 2 May 2022.
- 2021 Brief of Amicus Curiae – Bursch, John J., McCaleb, Gary S., Van Meter, Quentin L., Laidlaw, Michael K., Van Mol, Andre, Hansen, Jeffrey E. Brief of Amicus Curiae. United States Court of Appeals for the Eight Circuit. DYLAN BRANDT, et al., Plaintiffs-Appellees v. LESLIE RUTLEDGE, in her official capacity as the Arkansas Attorney General, et. al. Defendants-Appellants. 23 Nov 2021.
- 2020 Expert Witness – JULIANA PAOLI v. JOSEPH HUDSON et al. heard in THE SUPERIOR COURT OF THE STATE OF CALIFORNIA, COUNTY OF TULARE. CASE NO. 279126. 2021.
- 2021 Brief of Amicus Curiae – Bursch, John J., McCaleb, Gary S., Grossman, Miriam, Van Meter, Quentin L., Laidlaw, Michael K., Van Mol, Andre, Hansen, Jeffrey E.

- Brief of Amicus Curiae. United States Court of Appeals for the Eleventh Circuit. DREW ADAMS, Plaintiffs-Appellee v. SCHOOL BOARD OF ST. JOHNS COUNTY, FLORIDA, et. al. Defendants-Appellant. 26 Oct 2021.
- 2020 Expert Witness Affidavit 1 & 2 – Laidlaw MK. Supreme Court of British Columbia. File No. S2011599, Vancouver Registry. Between A.M. Plaintiff and Dr. F and Daniel McKee Defendants. 11/23/20 & 11/25/20.
- 2020 Brief of Amicus Curiae – Wenger, Randal L., McCaleb, Gary S., Grossman, Miriam, Laidlaw, Michael K., McCaleb, Gary S., Van Meter, Quentin L., Van Mol, Andre. Brief of Amicus Curiae. United States Court of Appeals for the Ninth Circuit. LINDSAY HECOX and JANE DOE, with her next friends Jean Doe and John Doe, Plaintiffs-Appellees v. BRADLEY LITTLE, in his official capacity as Governor of the State of Idaho, et. al. Defendant-Appellant. 19 Nov 2020
- 2020 Expert Witness Report – Laidlaw MK. United States District Court for the District of Arizona. DH and John Doe, Plaintiffs, vs. Jami Snyder, Director of the Arizona Health Care Cost Containment System, in her official capacity, Defendant. Case No. 4:20-cv-00335-SHR. 27 Sep 2020.
- 2019 Expert Witness Affidavit – Laidlaw MK. Court of Appeal File No. CA45940, Vancouver Registry. B.C. Supreme Court File No. E190334, between A.B. Respondent/Claimant, and C.D. Appellant/Respondent, and E.F. Respondent/Respondent. 24 Jun 2019.
- 2018 Brief of Amicus Curiae – Alliance Defending Freedom, Campbell, James A., Grossman, Miriam, Laidlaw, Michael K., McCaleb, Gary S., Van Meter, Quentin L., Van Mol, Andre. Brief of Amicus Curiae. United States Court of Appeals for the Eleventh Circuit. Drew Adams, Plaintiff-Appellee, v. School Board of St. Johns County, Florida, Defendant-Appellant. 12/27/2018.

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### PERSONAL

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Languages: Conversational Spanish, French

Tutor: Biochemistry, computer science, High School mentor

Computers: Ruby, Rails, Javascript, C++, C, Java, and HTML programming

## Appendix Attachment

12



IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF FLORIDA  
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.,

Plaintiffs,

v.

Case No. 4:22-cv-00325-RH-MAF

SIMONE MARSTILLER, et al.,

Defendants.

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**DECLARATION OF KRISTOPHER E. KALIEBE, M.D.**

I, Kristopher E. Kaliebe, M.D., 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, Kristopher Kaliebe, MD. am an associate professor at the University of South Florida in Tampa Florida. I am Board Certified in Psychiatry, Child and Adolescent Psychiatry and Forensic Psychiatry. I am a Distinguished Fellow at the American Academy of Child and Adolescent Psychiatry (AACAP). My clinical work has been primarily in University based clinics, Federally Qualified Health Centers and juvenile corrections. I have extensive teaching experience including medical students, general psychiatry residents, child and adolescent psychiatry fellows and forensic psychiatry fellows. My CV is attached.

3. I have been retained by the Defendants in the case to describe my experience with gender dysphoria patients and opine as to the state of the evidence supporting gender dysphoria treatments. I also have been asked to opine on the influence of activism and suppression of open inquiry which has distorted academic dialogue and made published research and expert

recommendations less trustworthy. If called to testify in this matter, I will testify truthfully based on my personal experience and knowledge.

4. My curriculum vitae contains a list of papers I have authored within the past 10 years.

I have testified in deposition or trial in the following cases over the past four years:

**Civil Testimony:**

*In the Interest of RW, LL, AP Minor Children* Circuit Court of the 13<sup>th</sup> judicial circuit, Juvenile Division, Tampa FL January 28, 2020

*Jeffrey Spivey, petitioner/father and Teresa Spivey N/K/A Teresa Cartwright, respondent/mother* Case No.: 2016 DR0471's, Circuit Court of the 12<sup>th</sup> judicial circuit in and for Manatee County Florida. February 28, 2020

*Re: The Marriage of Robyn Cohen McCarthy and John McCarthy* November 1, 2019 11<sup>th</sup> Judicial Circuit, Family Division, Dade County, Miami FL

**Criminal Testimony:**

*The State of Florida v. Bill Paul Marquardt* 5<sup>th</sup> Judicial Circuit, Sumner County, Florida, Bushnell Florida December 19, 2019

*The State of Florida v. Bill Paul Marquardt* 5<sup>th</sup> Judicial Circuit, Sumner County, Florida, Bushnell Florida August 24, 2022

*State of Florida v. Justin Mitchell Pennell*, 2020CF000159FAXWS, 6<sup>th</sup> Judicial Circuit in and for Pasco County, Florida March 23, 2022

**Civil Depositions:**

*Z.M.L., a minor, through her parents and guardians, -vs- D.R. Horton, Inc., a foreign corporation authorized to do business in Florida*, United States District Court, Middle Division of Florida, Tampa, May 6, 2021

*Julie Tarallo versus Blue Rock Partners, LLC et al.* in the Circuit Court for the 13<sup>th</sup> Judicial Circuit, Florida Civil Division. (2019-CA 012361.) June 3, 2022

*Carlton Collins, individually, and on behalf of his minor son, Connor Samuel Collins v. David R. Wallace, Sr., M.D.* Louisiana's 14<sup>th</sup> judicial district, Civil Suit: 2019 – 4128 – D, March 4<sup>th</sup>, 2022

**Criminal Deposition:**

*State of Florida v. Justin Mitchell Pennell*, 2020CF000159FAXWS, 6<sup>th</sup> Judicial Circuit of the State of Florida in and for Pasco County, March 11, 2022

5. I am being compensated at an hourly rate of \$400 per hour for my time preparing this declaration. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

6. I was awarded my medical degree in 1999, and subsequently completed general psychiatry, child and adolescent psychiatry and forensic psychiatry training. This training including education in human biology, human sexuality, development, brain functioning, normal development and psychopathology. Gender dysphoria and gender dysphoria treatment was part my professional training. I have additional training in Cognitive Behavioral Therapy and trauma-focused therapies. I have been providing psychotherapy and teaching psychotherapy to psychiatry trainees throughout my career. Since July 2005 I have worked as a university professor with primarily clinical psychiatric care and teaching duties. Since 2016 I have acted as a supervising physician at the University of South Florida's Silver Child Development Center. In this capacity my role is to function as a clinical supervisor and instructor. Child psychiatry residents and general psychiatry residents serve as the primary patient evaluators and clinicians. I evaluate new patients directly, and after see patients directly as needed. I oversee the resident's work products and function as the physician of record. Within this clinic I have evaluated and treated, along with resident physicians, patients with gender dysphoria. In addition to these direct clinical experiences, part of my scope of duties within the Silver Child Development Center is training residents regarding the treatment of patients, including patients with gender dysphoria. In addition to direct clinical care, I have been consulted by a colleague for my opinion regarding what would be the appropriate forensic and clinical approach regarding providing a letter as requested by an endocrinologist regarding a youth considering puberty blockers on a path toward sex hormone treatment and potential surgeries. Within the juvenile justice system I have been asked to provide a second opinion and coordinate care regarding a patient with gender dysphoria.

7. My review of the research concludes that the evidence base for gender dysphoria treatments is mixed and generally low quality. The administration of sex hormones and performing of surgeries are medical interventions with substantial risks, and as these interventions target otherwise healthy tissue, a high degree of evidence and certainty is demanded before such a life altering intervention. Until recently cross sex hormone and surgeries for gender dysphoria have been exceedingly rare, thus there exists nominal long term data. It is especially challenging to evaluate this evidence base due to changing definitions and epidemiology. The costs and benefits of medicalizing gender self-identification has not gone through academic inquiry with open rigorous academic review. Social affirmation can be considered a psychosocial treatment and also has an extremely limited evidence base as an intervention.

8. There is not an evidence base to support strictly “affirmative” psychotherapy for gender dysphoria. Psychotherapy, in general, should aim to help individuals gain a deeper understanding of themselves, develop coping skills and provide a neutral, unbiased process. The binary of affirmative psychotherapy versus conversion therapy for gender dysphoria is a serious misunderstanding of the complexities of ethical and effective psychotherapy. It is my opinion that insufficient data is available to make confident proclamation regarding the risks and benefits of treatment of gender dysphoria.

9. Open inquiry is the ability to ask questions and share ideas without risk of censure. It is fundamental to medical research and scientific progress. Within medicine and science the ability for constructive disagreement and the expression of divergent opinions has withered with regards to questions of biological sex, gender and gender medicine. Political and social pressures are not new to this line of research and clinical care and do not come from only one political pole or fraction of society. Yet especially within the last decade, academia, including academic medicine has become more tribal, moralizing and more likely to attempt to silence divergent opinions. This has led to a

suppression of research data, publication bias, and penalizing of divergent viewpoints. These dynamics have contributed to expert recommendations which exaggerate the strength of the evidence base for gender dysphoria.

10. I witnessed these dynamics personally at the American Psychiatric Association conference in May 2022. During a Clinical Perspectives where presenters opined that they questioned the evidence based supporting current practice regarding the treatment of transgender youth, a sizable crowd in the audience was disruptive. During the question and answer session, crowd members repeatedly made hostile ad-hominem statements towards the presenters while only a few questions responded to the evidence or viewpoints presented. Similarly, in 2018 Lisa Littman, MD presented her research data at American Academy of Child and Adolescent Psychiatry conference and received similar personal enmity which caused a colleague to remark he has never seen a presenter at a conference treated with such hostility. Dr. Littman is the same researcher who after her peer reviewed research was published by the journal PLOS ONE, disregarding the typical rules of scientific discourse, PLOS ONE had a re-editing of the publication with a commentary added, despite no finding of error or misconduct. Another colleague had a related difficult experience with editors of the American Academy of Psychiatry and the Law Newsletter. The editors would not permit him to describe in his article the problematic behaviors of youth who declared themselves to be transgender, thus undermining the exchange of important clinical data. Similarly, the 2022 American Academy of Child and Adolescent Psychiatry conference will feature at least 6 presentation related to gender dysphoria or transgender patients, none presenting new research. Yet a research Symposium which included a prominent international researcher, and was to feature detransitioners, was not accepted. Similarly, I submitted, with two other physicians, for a Special Interest Group which was to feature data on de-transitioning. This proposal was also not accepted. Likewise, when I wrote a *Letter to the Editor* of the major forensic psychiatric journal which expressed skepticism about a commentary

**CERTIFICATE OF SERVICE**

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

Dated: October 13, 2023

/s/ Mohammad O. Jazil