7/12/2023 5:08 PM
Velva L. Price
District Clerk
Travis County
D-1-GN-23-003616
Daniel Smith

CAUSE NO. _____

LAZARO LOE, individually and as parent and next friend of LUNA LOE, a minor; MARY MOE and MATTHEW MOE, individually and as parents and next friends of MAEVE MOE, a minor; NORA NOE, individually and as parent and next friend of NATHAN NOE, a minor; SARAH SOE and STEVEN SOE, individually and as parents and next friends of SAMANTHA SOE, a minor; GINA GOE, individually and as parent and next friend of GRAYSON GOE, a minor; PFLAG, INC.; RICHARD OGDEN ROBERTS III, M.D., on behalf of himself and his patients; DAVID L. PAUL, M.D., on behalf of himself and his patients; PATRICK W. O'MALLEY, M.D., on behalf of himself and his patients; and AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS, INC. d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ+ EQUALITY; *Plaintiffs*, v. THE STATE OF TEXAS; OFFICE OF THE ATTORNEY GENERAL OF TEXAS; JOHN SCOTT, in his official capacity as Provisional Attorney General; TEXAS MEDICAL BOARD; and TEXAS HEALTH AND HUMAN SERVICES COMMISSION, *Defendants*.	§	IN THE DISTRICT COURT OF 201ST, DISTRICT COURT TRAVIS COUNTY, TEXAS JUDICIAL DISTRICT

PLAINTIFFS' VERIFIED ORIGINAL PETITION FOR DECLARATORY JUDGMENT AND APPLICATION FOR TEMPORARY AND PERMANENT INJUNCTIVE RELIEF

Plaintiffs file this Verified Original Petition for Declaratory Judgment, and Application for Temporary and Permanent Injunctive Relief ("Petition") against the State of Texas, the Office of

the Attorney General of Texas, John Scott, in his official capacity as Provisional Attorney General ("Attorney General"), the Texas Medical Board, and Texas Health and Human Services Commission (collectively, "Defendants"). In support of their Petition, Plaintiffs respectfully show the following:

I. PRELIMINARY STATEMENT

Gender dysphoria is a medical condition characterized by the clinically significant distress caused by the incongruence between a person's gender identity and the sex they were assigned at birth. If left untreated, gender dysphoria can have dire and serious consequences for the health and wellbeing of transgender people, including adolescents. In Texas, adolescents who experience gender dysphoria currently have access to medically necessary care and treatment, which allows them to safely address their gender dysphoria and live as their true selves.

Many parents of transgender children in Texas have worked with their children's medical providers to ensure that their adolescent children receive the medically necessary course of care for their individual experiences of gender dysphoria. As parents, they are driven by their love for their children and desire to see them grow into happy, healthy, functioning adults, which is why they sought treatment from medical providers when their children expressed or exhibited gender dysphoria. These parents have seen that affirming their children, including by helping them access the medical care their providers have deemed necessary and appropriate, has helped them flourish.

Medical providers have long followed evidence-based and comprehensive clinical practice guidelines that recommend certain medical treatments for gender dysphoria. Decades of clinical experience and a large body of scientific and medical literature support these medical guidelines, which are recognized as authoritative by the major medical associations in the United States. They provide a framework for the safe and effective treatment of gender dysphoria, which for some adolescent patients includes puberty-delaying treatment and hormone therapy.

On June 2, 2023, Governor Greg Abbott of Texas signed into law Senate Bill 14 ("SB14" or the "Ban"), categorically banning the provision of necessary and often lifesaving medical treatment to transgender adolescents in Texas. The law passed despite the sustained and robust opposition of medical experts and the Texas families that stand to be severely negatively impacted. Absent intervention from this Court, the Ban will take effect on September 1, 2023.

Transgender adolescents in Texas are now faced with the loss of access to safe, effective, and medically necessary treatment, and their parents are faced with the loss of their ability to direct their children's medical treatment. The Ban violates the right to parental autonomy guaranteed by the Due Course of Law Clause of the Texas Constitution because it prevents Texas parents with transgender children suffering from gender dysphoria from accessing the medically necessary treatment that medical providers have recommended for their children. The Ban discriminates against parents seeking care for their transgender adolescent children in the exercise of their fundamental right to make decisions concerning the care, custody, and control of their children, by prohibiting them from seeking and following medical advice to protect the health and wellbeing of their children.

Parents must also contemplate drastic changes under the threat of the Ban, including uprooting their families and moving out of state or splitting up their families—all to ensure the health and safety of their transgender children. Many families already have lived through the impact of untreated gender dysphoria and have seen how treatment has been lifesaving for their children. If the Ban goes into effect, parents will be forced to take emotionally, physically, and financially difficult measures to try to ensure their children can access the medically necessary, safe, and effective treatment they need. Many, if not most, families do not have the resources to uproot their lives or to establish access to out-of-state medical treatment, however, and they are

terrified their children will lose access to the medical treatment they need to address their gender dysphoria.

The Ban also forces Texas physicians either to disregard well-established, evidence-based clinical practice guidelines, thereby significantly and severely compromising the health of their patients with gender dysphoria or, alternatively, to risk their livelihoods. The Ban does so by mandating revocation of licenses along with a panoply of other disciplinary actions if physicians provide transgender adolescent patients with medically necessary treatment. Therefore, the Ban infringes on Texas physicians' right of occupational freedom and deprives them of a vested property interest in their medical licenses.

Critically, puberty-delaying treatment and hormone therapy are also administered to treat minors with a variety of conditions other than gender dysphoria, and the Ban does not prohibit the same medical treatments for minors with all medical conditions; rather, it prohibits the treatments only when used to treat a transgender adolescent's gender dysphoria, even though the risks of the treatments are similar, if not the same, regardless of the condition for which they are prescribed. Texas is endangering the health and wellbeing of transgender adolescents and violating the Texas Constitution's guarantees of equality under the law by enacting a discriminatory and categorical prohibition on medical treatments for transgender youth that remain available to others.

The Ban was passed because of, and not in spite of, its impact on transgender adolescents, depriving them of necessary, safe, and effective medical treatment, thereby interfering with and overriding the clinical and evidence-based judgment of medical providers and the decision-making of loving parents.

If the Ban takes effect, it will have devastating consequences for transgender adolescents in Texas. They will be unable to obtain critical medical treatment that their physicians and other

medical providers have recommended and that their parents agree they need. Further, those already receiving medical treatment will have their treatment halted or otherwise are required to wean off their course of treatment. Many transgender adolescents will face the whiplash of losing their necessary medical treatment and experiencing unwanted and unbearable changes to their body as a result. For many, the prospect of losing the necessary medical treatment that has allowed them to thrive and live as their true selves is agonizing.

Because the Ban is unconstitutional, void, and unenforceable in its entirety, Plaintiffs seek temporary and permanent injunctions to prevent the Ban from taking effect and causing them immediate and irreparable harm.

II. DISCOVERY CONTROL PLAN & RULE 47 STATEMENT

1. Plaintiffs intend for discovery to be conducted under Level 3 of Texas Rule of Civil Procedure 190.

2. In accordance with Texas Rule of Civil Procedure 47(c), Plaintiffs state that they seek only non-monetary relief, excluding costs and attorney's fees. Accordingly, this lawsuit is not governed by the expedited actions process set forth in Texas Rule of Civil Procedure 169.

III. PARTIES

A. PLAINTIFFS

3. Plaintiffs **Lazaro Loe** and his daughter, **Luna Loe**; **Mary and Matthew Moe**, and their daughter, **Maeve Moe**; **Nora Noe** and her son, **Nathan Noe**; **Sarah and Steven Soe**, and their daughter, **Samantha Soe**; and **Gina Goe** and her son **Grayson Goe** (collectively, "Family Plaintiffs") are all residents of Texas.[1] The minors ("Minor Plaintiffs")—Luna, Maeve, Nathan,

[1] Minor Plaintiffs and their respective parents proceed using pseudonyms, rather than their legal names, to protect the privacy rights of the Minor Plaintiffs regarding their transgender status, medical diagnoses, and treatment, and for their safety. The Texas Rules of Civil Procedure recognize the need to protect a minor's identity. *See* Tex. R. Civ. P.

Samantha, and Grayson—are transgender; have been diagnosed with gender dysphoria, a serious medical condition; and have been prescribed and receive or anticipate receiving medical treatment for gender dysphoria, determined by their medical providers to be medically necessary. Plaintiffs Lazaro Loe, Mary and Matthew Moe, Nora Noe, Sarah and Steven Soe, and Gina Goe (collectively, "Parent Plaintiffs") are the parents of the Minor Plaintiffs who have each worked with their child's medical providers to ensure that their child is receiving the medically necessary course of treatment for their individual experience of gender dysphoria. The Parent Plaintiffs assert claims in this lawsuit on their own behalf and on behalf of their respective minor children.

4. Plaintiff **PFLAG** is the first and largest organization for lesbian, gay, bisexual, transgender, and queer ("LGBTQ+") people, their parents and families, and allies. PFLAG has a network of over 350 local chapters throughout the United States, 18 of which are in Texas. Individuals who identify as LGBTQ+ and their parents, families, and allies become PFLAG members by joining the national organization directly or through one of its local chapters. Of approximately 325,000 members and supporters nationwide, PFLAG has a roster of nearly 1,500 members in Texas, including many families of transgender youth who currently receive or will soon need to access the medical treatment for gender dysphoria prohibited by the Ban. PFLAG's

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21c(a)(3). Such goals would not be possible if the identities of Parent Plaintiffs were public. Indeed, not only do Texas rules "require use of an alias to refer to a minor" but courts "may also use an alias 'to [refer to] the minor's parent or other family member' to protect the minor's identity." *Int. of A.M.L.M.*, No. 13-18-00527-CV, 2019 WL 1187154, at *1 (Tex. App.—Corpus Christi Mar. 14, 2019, no pet. h.). Moreover, the disclosure of the Minor Plaintiffs' identities "would reveal matters of a highly sensitive and personal nature, specifically [Minor Plaintiffs'] transgender status and [their] diagnosed medical condition—gender dysphoria." *Foster v. Andersen*, No. 18-2552-DDC-KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019). "[O]ther courts have recognized the highly personal and sensitive nature of a person's transgender status and thus have permitted transgender litigants to proceed under pseudonym." *Id*. (collecting cases). Furthermore, as courts have recognized, the disclosure of a person's transgender status "exposes them to prejudice, discrimination, distress, harassment, and violence." *Arroyo Gonzalez v. Rossello Nevares*, 305 F. Supp. 3d 327, 332 (D.P.R. 2018); *see also Foster*, 2019 WL 329548, at *2. Such is the case here.

mission is to create a caring, just, and affirming world for LGBTQ+ people and those who love them. Encouraging and supporting parents and families of transgender and gender expansive people in affirming their children and helping them access the supports and care they need is central to PFLAG's mission. PFLAG asserts its claims in this lawsuit on behalf of its members.[2] The Family Plaintiffs are members of PFLAG.

5. Plaintiffs **Richard Ogden Roberts III, M.D.** ("Dr. Roberts"), **David L. Paul, M.D.** ("Dr. Paul"), and **Patrick W. O'Malley, M.D.** ("Dr. O'Malley") (collectively, "Physician Plaintiffs") are physicians licensed to practice medicine in the State of Texas. The Physician Plaintiffs have existing and ongoing physician-patient relationships with transgender youth in Texas diagnosed with gender dysphoria who would be impacted by the Ban. But for the Ban, the Physician Plaintiffs would continue to treat these patients, and perform or prescribe SB14's prohibited procedures and treatments according to generally accepted standard of care for the treatment of gender dysphoria. The Physician Plaintiffs are residents of Texas and assert claims in this lawsuit on their own behalf and on behalf of their respective patients.

6. Plaintiff **GLMA** is a 501(c)(3) national membership nonprofit organization based in Washington, D.C., and incorporated in California. GLMA's mission is to ensure health equity for LGBTQ+ people and equality for LGBTQ+ health professionals in their work and learning environments. GLMA's membership includes approximately 1,000-member physicians, nurses, advanced practice nurses, physician assistants, researchers and academics, behavioral health

[2] Texas courts recognize that membership organizations may have standing to sue on behalf of their members and determine such standing with a three-prong test. *See Tex. Ass'n of Bus. v. Tex. Air Control Bd.*, 852 S.W.2d 440 (Tex. 1993); *see also Hunt v. Washington State Apple Advert. Comm'n*, 432 U.S. 333 (1977). The three-prong test set forth in *Texas Association of Businesses* allows an organization to sue on behalf of its members when: (1) the members would otherwise have standing to sue in their own right; (2) the interests the organization seeks to protect are germane to the organization's purpose; and (3) neither the claim asserted nor the relief requests requires the participation of individual members in the lawsuit. 852 S.W.2d at 447. Each of these prongs is met here.

specialists, health profession students, and other health professionals. GLMA asserts its claims in this lawsuit on behalf of its members. The Physician Plaintiffs are members of GLMA.

B. DEFENDANTS

7. Defendant **The State of Texas** is responsible for the enforcement of Texas laws, including its categorical ban on the provision of necessary and often lifesaving medical treatment to transgender adolescents. The State of Texas may be served with process through the Texas Secretary of State, 1019 Brazos Street, Austin, Texas 78701.

8. Defendant **Office of the Attorney General of the State of Texas** ("OAG") is an agency of the State of Texas. SB14 empowers the Attorney General to file an action to enforce the subchapter it adds to the Health and Safety Code to restrain or enjoin any person he has reason to believe is committing, has committed, or is about to violate the Ban. SB14 § 2 (proposed Tex. Health & Safety Code §§ 161.702, 161.706). The Attorney General is additionally empowered to institute actions against physicians licensed in Texas who violate or threaten to violate any provision of the Texas Medical Practice Act, including provisions amended by SB14 to deem the provision of medical treatment for gender dysphoria a prohibited practice. Tex. Occ. Code §§ 165.101, 165.152. Defendant OAG may be served with process by serving the Provisional Attorney General, John Scott, at the Office of the Attorney General, 300 West 15th Street, Austin, Texas 78701.

9. Defendant **John Scott** is the Provisional Attorney General ("AG") of the State of Texas and head of the OAG. As noted above, SB14 gives the AG direct enforcement authority of SB14, in addition to preexisting authority to enforce any provision of the Texas Medical Practice

Act. Defendant John Scott is sued in his official capacity and may be served with process at the Office of the Attorney General, 300 West 15th Street, Austin, Texas 78701.[3]

10. Defendant **Texas Medical Board** ("TMB") is the state agency mandated to regulate the practice of medicine in Texas. Among other powers and duties, TMB initiates and enforces disciplinary action against licensed physicians who violate any provision of the Texas Medical Practice Act. *See, e.g.*, Tex. Occ. Code §§ 164.001, 165.001, 165.051. SB14 mandates that TMB "shall revoke the license or other authorization to practice medicine of a physician" who violates the Ban. SB14 § 5 (proposed Tex. Occ. Code § 164.0552); *id*. § 2 (proposed Tex. Health & Safety Code § 161.702). TMB is further authorized to impose a range of disciplinary measures and penalties on a physician who (i) commits a "prohibited practice" as defined in Section 164.052 of the Texas Occupations Code, which SB14 amends to include treating an adolescent's gender dysphoria with any of the prohibited procedures, Tex. Occ. Code § 164.051; SB14 § 2 (proposed Tex. Occ. Code § 164.052(a)(24)); and (ii) violates any state law "connected with the physician's practice of medicine" because such violation constitutes per se "unprofessional or dishonorable conduct." Tex. Occ. Code §§ 164.053(a)(1), 164.052(a)(5); *see also generally* Tex. Occ. Code §§ 165.001 *et seq.*, 165.051, 165.052. TMB may be served with process by serving its Executive Director, Stephen Brint Carlton, at 1801 Congress Avenue, Suite 9.200, Austin, Texas 78701.

11. Defendant **Texas Health and Human Services Commission** ("HHSC") is a state agency. The HHSC Executive Commissioner has "general supervision and control over all matters related to the health of citizens" in Texas and specifically retains all policymaking authority over

[3] Effective 10 a.m. on July 14, 2023, Angela Colmenero will succeed John Scott as Provisional Attorney General of Texas. *See* Press Release, Off. of the Texas Governor, Governor Abbott Appoints Angela Colmenero As Interim Attorney General Of Texas, (July 10, 2023), https://gov.texas.gov/news/post/governor-abbott-appoints-angela-colmenero-as-interim-attorney-general-of-texas/.

the child health plan. Tex. Health & Safety Code §§ 12.001, 62.055(e). HHSC also retains ultimate authority over the Texas medical assistance program. Tex. Hum. Res. Code § 32.021. HHSC will therefore be responsible for enforcing provisions of SB14 that prohibit the use of public money to medically treat transgender adolescents with gender dysphoria. HHSC may be served with process by serving its Commissioner, Cecile Erwin Young, at 4900 N. Lamar Blvd., Austin Texas 78751.

IV. JURISDICTION AND VENUE

12. This Court has jurisdiction over this matter, pursuant to the Texas Uniform Declaratory Judgments Act, Texas Civil Practice and Remedies Code § 37.001, *et seq*. ("UDJA"), Sections 24.007 and 24.008 of the Texas Government Code, and the Texas Constitution, Article V, § 8.

13. This action is brought pursuant to Texas Rules of Civil Procedure 680 to 693, Texas Civil Practice and Remedies Code Chapter 65, and the common law of Texas to obtain declaratory and injunctive relief against Defendants.

14. This Court has jurisdiction over the parties because all Defendants reside or have their principal place of business in Texas.

15. Venue is proper in Travis County because Defendants State of Texas, OAG, TMB, and HHSC have their principal office in Travis County, Tex. Civ. Prac. & Rem. Code § 15.002(a)(3), and because all or a substantial part of the events giving rise to the claims occurred in Travis County, *id*. § 15.002(a)(1).

IV. FACTUAL BACKGROUND

A. Medical Guidelines for Treating Adolescents with Gender Dysphoria

16. Health professionals,[4] including physicians and other health care providers, in Texas use evidence-based, well-researched, and widely accepted clinical practice and medical guidelines to assess, diagnose, and treat adolescents with gender dysphoria. Decades of clinical experience and a large body of research have demonstrated that these treatments are safe and effective at treating gender dysphoria in adolescents, and consequently inform how this treatment is provided.[5]

17. Gender identity refers to a person's internal sense of belonging to a particular gender.

18. Although the precise origin of gender identity is unknown, a person's gender identity is a fundamental aspect of human development. There is a general medical consensus that there is a significant biological component to gender identity.

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[4] SB14 defines the terms "physicians" and "health care providers" distinctly. Throughout this petition, Plaintiffs utilize the terms "health professionals" and "medical providers," which are both meant to be inclusive of "physicians" and "health care providers" as defined within SB 14, as well as other health professionals.

[5] Plaintiffs incorporate the Affidavit of Dr. Daniel Shumer, M.D., the Affidavit of Dr. Aron Janssen, M.D., and the Affidavit of Dr. Johanna Olson-Kennedy, M.D., M.S., attached hereto as Ex. 15-17, by reference as though fully set forth herein.

Dr. Shumer is a pediatric endocrinologist with over 8 years of experience treating transgender adolescents with gender dysphoria, the Clinical Director of the Child and Adolescent Gender Clinic at Mott Children's Hospital at Michigan Medicine, and the Medical Director of the Comprehensive Gender Services Program at Michigan Medicine.

Dr. Janssen is a child and adolescent psychiatrist with over 12 years of experience treating children and adolescents with gender dysphoria and the Vice Chair of the Pritzker Department of Psychiatry and Behavioral Health at the Ann and Robert H. Lurie Children's Hospital of Chicago.

Dr. Olson-Kennedy is a pediatrician and adolescent medicine physician with over 17 years providing health care to transgender youth and gender diverse children as well as conducting clinical research regarding the treatment of gender dysphoria, and the Medical Director of the Center for Transyouth Health and Development at Children's Hospital Los Angeles.

19. Everyone has a gender identity, and a person's gender identity is durable and cannot be altered voluntarily or changed through medical intervention.

20. A person's gender identity usually matches the sex they were designated at birth based on their external genitalia.[6]

21. Most boys are designated male at birth based on their external genital anatomy, and most girls are designated female at birth based on their external genital anatomy. But transgender people have a gender identity that differs from the sex assigned to them at birth.

22. A transgender boy is someone who was assigned a female sex at birth but has a male gender identity. A transgender girl is someone who was assigned a male sex at birth but has a female gender identity. Transgender people cannot simply turn off their gender identity like a switch, just as non-transgender (also known as "cisgender") people cannot turn off their gender identity like a switch. Gender identity is an inherent and core aspect of a person's identity.

23. Some transgender people become aware of having a gender identity that does not match their assigned sex early in childhood. For others, the onset of puberty and the resulting physical changes in their bodies lead them to recognize that their gender identity is not aligned with their sex assigned at birth.

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[6] Plaintiffs use the terms "sex designated at birth" or "sex assigned at birth" because they are more precise than the term "biological sex," used in SB14. There are many biological sex characteristics, and they do not always align with each other. This includes the characteristics that SB14 declares determine "biological sex,"—i.e., "sex organs, chromosomes, and endogenous profiles." For example, some people with intersex characteristics may have a chromosomal configuration typically associated with a male sex designation but genital characteristics typically associated with a female sex designation. For these reasons, the Endocrine Society, an international medical organization of over 18,000 endocrinology researchers and clinicians, warns practitioners that "the terms biological sex and biological male or female are imprecise and should be avoided." Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY AND METABOLISM 3869, 3875 tbl.1 (2017) ("Endocrine Society Clinical Guidelines"), https://academic.oup.com/jcem/article/102/11/3869/4157558.

24. Being transgender is not a medical condition to be treated or cured. But gender dysphoria—the clinically significant distress that some transgender people experience as a result of the incongruence between their gender identity and sex assigned at birth—is a serious medical condition that can cause clinically significant distress and discomfort.[7]

25. According to the American Psychiatric Association's *Diagnostic & Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* ("DSM-5-TR"), "gender dysphoria" is the diagnostic term for the condition experienced by some transgender people of clinically significant distress resulting from the lack of congruence between their gender identity and the sex assigned to them at birth. To be diagnosed with gender dysphoria, the incongruence must have persisted for at least six months and be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.[8]

26. If left untreated, gender dysphoria can result in negative mental health outcomes, including severe anxiety and depression, post-traumatic stress disorder, eating disorders, substance abuse, self-harm, and suicidality.

27. Many transgender adolescents with untreated gender dysphoria therefore suffer significant distress and experience depression and anxiety as a result of not being able to obtain medical treatment. Self-harm and suicidal ideation are exceedingly and unfortunately common. Indeed, suicidality among transgender adolescents is a crisis. In one survey, more than half of

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[7] *See* Eric Yarbrough et al., *Gender Dysphoria Diagnosis*, in *A Guide for Working With Transgender and Gender Nonconforming Patients,* Am. Psychiatric Ass'n (Nov. 2017), https://www.psychiatry.org/psychiatrists/diversity/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis.

[8] Am. Psychiatric Ass'n, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, TEXT REVISION F64.0 (5th ed. 2022).

transgender youths had seriously contemplated suicide.[9] Studies have found that as many as 40% of transgender people have attempted suicide at some point in their lives.[10]

28. However, when adolescents have access medical treatment for their gender dysphoria, such as puberty-delaying medications and hormone therapy, which prevent them from going through endogenous puberty and allows them to go through puberty more consistent with their gender identity, their dysphoria decreases and their mental health improves.

29. The goal of treatment for gender dysphoria is not to change someone's gender identity, but rather to resolve the distress associated with the incongruence between a transgender person's assigned sex at birth and their gender identity.

30. The World Professional Association for Transgender Health ("WPATH") and the Endocrine Society have published evidence-based and widely accepted clinical practice guidelines for the assessment, diagnosis, and treatment of gender dysphoria.[11] The medical treatment for gender dysphoria seeks to eliminate or alleviate the clinically significant distress by helping a transgender person live in alignment with their gender identity. This treatment is sometimes referred to as "gender transition," "transition-related care," or "gender-affirming care." These clinical practice guidelines are widely accepted as best practices for the treatment of adolescents and adults diagnosed with gender dysphoria and have been recognized as authoritative by leading

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[9] Trevor Project, National Survey on LGBTQ Youth Mental Health 2022 at 6 (2022), https://www.thetrevorproject.org/survey-2022/assets/static/trevor01_2022survey_final.pdf (59 percent of transgender boys, 48 percent of transgender girls, and 53 percent of nonbinary youth considered suicide in the past year).

[10] Sandy E. James Et Al., Nat'l Ctr. for Transgender Equal., Report of the 2015 U.S. Transgender Survey at 5 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-FullReport-Dec17.pdf.

[11] *See* Eli Coleman et al., World Pro. Ass'n for Transgender Health, *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. TRANSGENDER HEALTH (Sept. 15, 2022), at 51 ("WPATH Standards of Care"), https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644; Endocrine Society Clinical Guidelines at 3869.

medical organizations, including the American Academy of Pediatrics, American Medical Association, Academy of Child & Adolescent Psychiatrists, American Psychiatric Association, Pediatric Endocrine Society, and Endocrine Society, among others, which agree that medical treatment of gender dysphoria is safe, effective, and medically necessary for many adolescents suffering from gender dysphoria.

31. Both clinical experience and multiple medical and scientific studies confirm that for many adolescents, this treatment not only is safe and effective, but it also is positively transformative. Indeed, transgender adolescents able to access this medically necessary and evidence-based medical treatment often go from painful suffering to thriving.

32. The precise treatment for gender dysphoria depends upon each person's individualized needs, and the guidelines for medical treatment differ depending on whether the treatment is for an adolescent or an adult.

33. Before the onset of puberty, consistent with the WPATH Standards of Care and the Endocrine Society Clinical Guidelines, no interventions beyond mental health counseling are recommended or provided to any person. In other words, gender transition does not include any medical intervention, such as pharmaceutical or surgical intervention, before puberty. Care is limited to supportive mental health counseling. Any transition before puberty is limited to "social transition," which means allowing a transgender child to live and be socially recognized in accordance with their gender identity. Typically, social transition can include allowing children to wear clothing aligned with their gender identity, cut or grow their hair, use chosen names and pronouns, and use restrooms and other sex-separated facilities aligned with their gender identity instead of the sex assigned to them at birth.

34. Under the WPATH Standards of Care and the Endocrine Society Clinical Guidelines, medical interventions may become medically necessary and appropriate as a transgender person reaches puberty. In providing medical treatment to adolescents with gender dysphoria, qualified medical providers work in close consultation with mental health professionals experienced in diagnosing and treating gender dysphoria.

35. For many transgender adolescents, the onset of puberty leading to physical changes in their bodies that are incongruent with their gender identities can cause severe distress. Puberty-delaying medication allows transgender adolescents to avoid this, therefore minimizing and potentially preventing the heightened gender dysphoria caused by the development of secondary sex characteristics incongruent with their gender identity.

36. Under the Endocrine Society Clinical Guidelines, transgender adolescents who have reached the onset of puberty may be eligible for puberty-delaying treatment if:

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

- And the adolescent:
    - Has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility;
    - Has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process;
- And a pediatric endocrinologist or other clinician experienced in pubertal assessment:
    - Agrees with the indication for gonadotropin-releasing hormone ("GnRH") agonist treatment;
    - Has confirmed that puberty has started in the adolescent; and
    - Has confirmed that there are no medical contraindications to GnRH agonist treatment.[12]

37. Similarly, the WPATH Standards of Care, Version 8 ("SOC") recommend that health professionals, including physicians and other health care providers, assessing transgender adolescents only recommend the provision of puberty-delaying medications as treatment when: (a) the adolescent meets the necessary diagnostic criteria; (b) the experience of gender incongruence is marked and sustained over time; (c) the adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment; (d) the adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to

[12] Endocrine Society Clinical Guidelines at 3878 tbl.5.

consent, and treatment have been addressed; (e) the adolescent has been informed of the reproductive effects, including effects on fertility, and these have been discussed in the context of the adolescent's stage of pubertal development; and (f) the adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated.[13] The WPATH SOC further recommend that health professionals, including physicians and other health care providers, working with transgender adolescents undertake a comprehensive biopsychosocial assessment of the adolescent prior to initiating any medical treatment, and that this be accomplished in a collaborative and supportive manner.[14]

38. Puberty-delaying treatment is reversible. If an adolescent discontinues the medication, endogenous puberty resumes. Puberty-delaying treatment does not cause infertility.

39. For some older transgender adolescents, it may be medically necessary and appropriate to treat them with gender-affirming hormone therapy (e.g., testosterone for transgender boys and estrogen and testosterone suppression for transgender girls).

40. Under the Endocrine Society Clinical Guidelines, transgender adolescents may be eligible for gender-affirming hormone therapy if:

- A qualified mental health professional has confirmed:
    - The persistence of gender dysphoria;
    - Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's environment and functioning are stable enough to start sex hormone treatment;

[13] WPATH Standards of Care, at S48.

[14] WPATH Standards of Care, at S50-S51.

- The adolescent has sufficient mental capacity to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment;

- And the adolescent:
  - Has been informed of the partly irreversible effects and side effects of treatment (including potential loss of fertility and options to preserve fertility);
  - Has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process;
- And a pediatric endocrinologist or other clinician experienced in pubertal induction:
  - Agrees with the indication for sex hormone treatment; and
  - Has confirmed that there are no medical contraindications to sex hormone treatment.[15]

41. As with puberty-delaying medications, the WPATH Standards of Care recommend that health professionals, including physicians and other health care providers, assessing transgender adolescents only recommend the provision of gender-affirming hormones as treatment when: (a) the adolescent meets the necessary diagnostic criteria; (b) the experience of gender incongruence is marked and sustained over time; (c) the adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment; (d) the adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to

[15] Endocrine Society Clinical Guidelines at 3878 tbl.5.

consent, and treatment have been addressed; and (e) the adolescent has been informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development.[16] Again, a comprehensive biopsychosocial assessment of the adolescent prior to initiating any medical treatment is recommended.[17]

42. Gender-affirming hormone therapy does not necessarily result in a loss of fertility, and many individuals treated with hormone therapy can and do still biologically conceive children.

43. As with all medications that could affect fertility, transgender adolescents and their parents or guardians are counseled on the potential risks of the medical intervention, and treatment is only initiated where parents and adolescents are properly informed and consent/assent to the care.

44. Adolescents who first receive treatment later in puberty and are treated only with gender-affirming hormone therapy (and not puberty-delaying treatment) also go through a hormonal puberty consistent with their gender identity. However, they will have undergone physical changes associated with their endogenous puberty that may not be wholly reversed by hormone therapy or even surgery later in life.

45. Under the WPATH Standards of Care, transgender adolescents also may receive medically necessary chest reconstructive surgeries before the age of majority provided that the adolescent has lived in their affirmed gender for a significant period of time.[18]

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[16] WPATH Standards of Care, at S48.

[17] WPATH Standards of Care, at S50-S51.

[18] WPATH Standards of Care, at S66.

46. Medical treatment recommended for and provided to transgender adolescents with gender dysphoria can substantially reduce lifelong gender dysphoria and eliminate the medical need for surgery or other medical interventions later in life.

47. Providing medical treatment for gender dysphoria can be lifesaving treatment and positively change the short- and long-term health outcomes for transgender adolescents.

48. The medical treatments used to treat gender dysphoria are also used to treat other conditions, including conditions for adolescents. The Ban does not prohibit these treatments when used to treat any condition other than gender dysphoria, even though the treatments have comparable risks and side effects to those that can be present when treating gender dysphoria. *See, e.g.*, SB14 § 2 (proposed Tex. Health & Safety Code § 161.703(a)). The use of these treatments for gender dysphoria is not any riskier than for other conditions and diagnoses for which the same treatments are regularly used.

B. The Texas Legislature's Passage of the Ban

49. On May 19, 2023, the Texas State Legislature passed SB14. Governor Abbott signed the Ban into law on June 2, 2023, and it is scheduled to take effect on September 1, 2023.

50. The Ban prohibits physicians and other healthcare providers from providing, prescribing, administering, or dispensing medical procedures and treatments "[f]or the purpose of transitioning a child's biological sex as determined by the sex organs, chromosomes, and endogenous profiles of the child or affirming the child's perception of the child's sex if that perception is inconsistent with the child's biological sex." SB14 § 2 (proposed Tex. Health & Safety Code §§ 161.702, 161.706).

51. Specifically, the Ban prohibits "a physician or health care provider" from "knowingly" providing a range of medical treatments used to treat gender dysphoria, including "puberty suppression or blocking prescription drugs to stop or delay normal puberty,"

"supraphysiological doses of testosterone to females," "supraphysiologic doses of estrogen to males," and various surgeries, including "mastectom[ies]" (the "Prohibited Care"). SB14 § 2 (proposed Tex. Health & Safety Code § 161.702).

52. Notably, the Ban prohibits provision of these medical treatments only "[f]or the purpose of transitioning a child's biological sex" or for "affirming the child's perception of the child's sex if that perception is inconsistent with the child's biological sex." SB14 § 2 (proposed Tex. Health & Safety Code § 161.702). Under the Ban, the provision of these same medical treatments is permitted for any other medical diagnosis, including but not limited to precocious puberty or "a medically verifiable genetic disorder of sex development," which are specifically identified as exceptions under the Ban. SB14 § 2 (proposed Tex. Health & Safety Code § 161.703).

53. The Ban further bars coverage for and reimbursement of Prohibited Care under a patient's Medicaid or Children's Health Insurance Program ("CHIP") plan and strips state funding of any kind from any medical provider, medical institution, "entity, organization, or individual that provides or facilitates" such care to transgender youth. SB14 § 2 (proposed Tex. Health & Safety Code §§ 161.704, 161.705); *id*. § 3 (proposed Tex. Human Resources Code § 32.024). It also grants the Attorney General carte blanche enforcement authority to bring an action for injunctive relief against "a[ny] person" if the Attorney General has "reason to believe that [the] person is committing, has committed, or is about to commit" a violation of the Ban. SB14 § 2 (proposed Tex. Health & Safety Code § 161.706).

54. Finally, the Ban subjects medical providers who provide or offer to provide Prohibited Care to a range of penalties, including requiring that the Texas Medical Board "shall revoke the license or other authorization to practice medicine" of any physician who violates the

Ban. SB14 § 4 (proposed Tex. Occ. Code § 164.052(a)); *id.* § 5 (proposed Tex. Occ. Code § 164.0552).

55. The legislative history of the Ban demonstrates it has no legitimate justification and was instead motivated and justified by Texas lawmakers' anti-transgender animus and disregard for public input and well-established, evidence-based medical science.

56. At various points during legislative debates, legislators who supported the Ban defended the bill based on general criticisms, stereotypes, and misunderstandings of transgender people. The language that lawmakers used conveyed clear animus towards transgender youth because it intentionally erased and denied their very existence. For example, SB14's lead author, Senator Donna Campbell called gender dysphoria a "social contagion" purposefully perpetuated by mental health professionals during the Senate committee hearing on this bill.[19] In a separate interview, Senator Campbell referred to gender dysphoria as a "mental delusion."[20]

57. The lead House author of SB14, Representative Tom Oliverson, referred to medical care for the treatment of gender dysphoria as "harmful experimentation" and equated the provision of this medical care to the opioid epidemic and to the use of "lobotom[ies] for the treatment of schizophrenia or severe depression."[21] Representative Oliverson admitted during the House floor debate that forcing transgender youth to "wean off" medically necessary care poses a "concern"

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[19] Debate on Tex. S.B. 14 in the Senate Committee on State Affairs, 88th Leg. (Mar. 16, 2023), https://tlcsenate.granicus.com/MediaPlayer.php?view_id=53&clip_id=17404 (at 05:20).

[20] Texas Values (@txvalues), Twitter (May 12, 2023, 2:45 PM), https://twitter.com/txvalues/status/1657109671361105936?s=20.

[21] Debate on Tex. S.B. 14 on the Floor of the House, 88th Leg. (May 12, 2023), https://tlchouse.granicus.com/MediaPlayer.php?view_id=80&clip_id=24872 (at 5:28:35– 5:33:56).

because "there is no . . . scientific guidance as to the process for removing those medications."[22] Despite this acknowledgement, Representative Oliverson and a majority of his colleagues still voted to ban this medically necessary care for all transgender youth who need it.

58. Representative Oliverson called this Ban the "least invasive thing that we can do" and "the least harmful thing that we can do for these patients,"[23] but SB14 is far from narrowly tailored, or even rationally related, to any compelling or legitimate government interest.

59. During the second reading of SB14, the Texas House rejected 19 amendments, including several that would have substantially narrowed the Ban's current scope of prohibiting all medically necessary treatment for transgender youth diagnosed with gender dysphoria.[24] The Texas Senate initially voted to pass a "grandfathering clause" that would have made the Ban "not apply to the provision by a physician or health care provider of a nonsurgical gender transitioning or gender reassignment procedure or treatment to a child if the procedure or treatment is continuing a procedure or course of treatment that began 90 days before the effective date of this Act."[25] The law's enactment date was also pushed back from September 1 to December 1, 2023, and the Texas Senate unanimously voted to approve both of these amendments.[26] A week later, bill author Senator Campbell and her colleagues suspended the Senate rules to reconsider this vote, withdraw

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[22] *Id.* at 6:17:30–6:19:23.

[23] *Id.* at 6:19:00-6:19:20.

[24] H.J. of Tex., 88th Leg. (May 12, 2023), https://journals.house.texas.gov/hjrnl/88r/pdf/88RDAY62FINAL.PDF#page=124.

[25] Floor Amendment No. 1, S.J. of Tex., 88th Leg. (March 29, 2023), https://journals.senate.texas.gov/sjrnl/88r/pdf/88RSJ03-29-F.PDF#page=17.

[26] *Id.*

these amendments, and pass a Ban that was far more stringent and completely barred all medically necessary care for transgender youth who have been diagnosed with gender dysphoria.[27]

60. These amendments show that the Texas Legislature considered (and even provisionally approved) changes to the Ban that would be more narrowly tailored than the ultimate version but ended up rejecting them. The text of SB14, as well as the Ban's legislative history, evinces clear animus towards young transgender Texans and a deliberate disregard of their health, wellbeing, and needs based on evidence-based medical science.

61. In passing this Ban, the Texas Legislature ignored the testimony of hundreds of transgender Texans who have received or someday might need medical care for the treatment for gender dysphoria, and the positive and transformational impact that care has had on their health and overall wellbeing.

62. The Texas Legislature also ignored the testimony of parents of transgender children with gender dysphoria, who pleaded with lawmakers not to risk their children's health by stripping them of the medical treatment that enables them to survive and thrive.

63. The Texas Legislature also ignored testimony from Texas doctors and medical professionals about the damage that the Ban would cause to the health and wellbeing of transgender youth. For example, the Texas Pediatric Society, which represents more than 4,800 pediatricians, pediatric subspecialists, and medical students, testified unequivocally against the bill, stating: "As physicians, we must be able to practice medicine that is informed by our years of medical education, training, experience, and available evidence, which does evolve with time. All medical treatments involve weighing the risks and benefits of both treating a condition and not

[27] Vote Reconsidered on Senate Bill 14, S.J. of Tex., 88th Leg. (April 3, 2023), https://journals.senate.texas.gov/sjrnl/88r/pdf/88RSJ04-03-F.PDF#page=12.

treating it. Gender affirming care in the treatment of gender dysphoria is no different, and considering the various factors that come into play for individual patients and families is something that is best left to the patients and their families with guidance and consultation from their health care providers—without threat of punishment. A blanket ban on these medical treatments is a very blunt instrument for the state to use and prohibits treatment options that are critical for the health and wellbeing of transgender youth with gender dysphoria."[28]

64. The Texas Legislature also ignored testimony from mental health providers about the catastrophic damage that the Ban would cause to the mental health and wellbeing of transgender youth, including causing an increase in anxiety, depression, suicidal ideation, and suicide attempts. For example, the Texas Psychological Association testified at the Senate committee hearing, "The kind of medical care that SB14 seeks to prohibit for children is literally lifesaving. . . . We have considerable data about the important mental health benefits of medical interventions, including puberty blockers and hormone treatments, for transgender youth. Research has demonstrated that gender-affirming medical care decreases suicidality, depression, and anxiety, as well as increases self-confidence and improves body image."[29]

65. While ignoring this scientific research and testimony of transgender Texans, their families, medical experts, and mental health providers, the Texas Legislature stopped hundreds of Texans from testifying against this bill and its companion legislation. The House Public Health Committee cut off public testimony on a House companion bill to SB14, which prevented over

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[28] Louis Appel on behalf of the Texas Pediatric Society, Testimony before the Texas Senate State Affairs, SB 14 (March 16, 2023), https://txpeds.org/sites/txpeds.org/files/documents/newsletters/sb-14-sen-sa-appel-3-16-23-final.pdf.

[29] Debate on Tex. S.B. 14 in the Senate Committee on State Affairs, 88th Leg. (Mar. 16, 2023), https://tlcsenate.granicus.com/MediaPlayer.php?view_id=53&clip_id=17404 (at 1:36:10-1:38:05).

400 people from testifying. At that hearing, over 2,800 people registered against the bill, while less than 100 people registered in support of it.[30]

C. The State of Texas's Anti-Transgender Agenda

66. The Ban is just one piece of the Texas Legislature's discriminatory agenda for targeting transgender Texans. This year, Texas led the nation in introducing the highest number of anti-LGBTQ+ pieces of legislation, with over 140 bills filed specifically targeting the LGBTQ+ community.[31]

67. The Texas executive branch has also made numerous attempts to target transgender Texans, their medical treatment, and their families. For example, in December 2021, now-suspended Attorney General Ken Paxton initiated an investigation of two pharmaceutical companies that sell puberty-delaying medications, calling the "use of puberty blockers on young teens and minors" to treat gender dysphoria "dangerous and reckless."[32]

68. Just months later, on February 22, 2022, Paxton released a non-binding opinion claiming that necessary, evidence-based gender-affirming medical treatment for transgender youth is per se "child abuse" under Texas law. The next day, Governor Abbott directed the Texas Department of Family Protective Services ("DFPS") to investigate families of transgender youth who receive gender-affirming medical care for the treatment of gender dysphoria. Later that day, DFPS Commissioner Jamie Masters announced that the department would investigate families

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[30] William Melhado and Alex Nguyen, *Transgender Texans and Doctors Say Republican Lawmakers Misconstrue What Science Says About Puberty Blockers and Hormone Therapy*, Tex. Tribune (Mar. 28, 2023), https://www.texastribune.org/2023/03/24/texas-legislature-transgender-health-care/.

[31] *Legislative Bill Tracker,* Equality Texas (2023), https://www.equalitytexas.org/legislature/legislative-bill-tracker-2023/

[32] *AG Paxton to Investigate Promotion of Puberty Blockers in Children*, Ken Paxton Atty. Gen. of Tex. (Dec. 13, 2021), https://www.texasattorneygeneral.gov/news/releases/ag-paxton-investigate-promotion-puberty-blockers-children.

alleged to be providing this treatment, and the department quickly initiated investigations into multiple families. Families of transgender adolescents subjected to these unlawful investigations filed two lawsuits challenging the Governor's directive and DFPS's operationalization thereof, securing temporary injunctive relief barring further investigations while the litigation proceeds. *See Doe v. Abbott*, Cause No. D-1-GN-22-000977 (in the 353rd District Court of Travis County, Texas); *PFLAG, Inc. v. Abbott,* Cause No. D-1-GN-22-002569 (in the 459th District Court of Travis County, Texas). The families obtained temporary injunctive relief from Judge Amy Clark Meachum, the defendants appealed, and the two lawsuits are currently pending in the Third Court of Appeals. *See In re Abbott*, 645 S.W.3d 276, 284 (Tex. 2022); *Masters v. Voe*, No. 03-22-00420-CV, 2022 WL 4359561 (Tex. App.—Austin, Sept. 20, 2022, no pet.).

69. This May, as the Legislature was debating SB14, the OAG also announced investigations into two hospitals that have provided medical treatment to transgender youth: Dell Children's Medical Center[33] and Texas Children's Hospital.[34] As part of these investigations, the Attorney General demanded that the hospitals turn over sensitive medical documents relating to medical care for the treatment of gender dysphoria and referred to healthcare professionals who provide this care as "unhinged activists."[35] Notably, the OAG's Request to Examine notices and document requests (particularly in the definition of "Gender Transitioning and Reassignment

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[33] Office of the Attorney General, *Request to Examine*, (May 5, 2023) (Dell Children's Medical Center), https://www.texasattorneygeneral.gov/sites/default/files/images/press/RTE.pdf.

[34] Office of the Attorney General, *Request to Examine*, (May 19, 2023) (Texas Children's Hospital), https://www.texasattorneygeneral.gov/sites/default/files/images/press/RTE_0.pdf

[35] *Paxton Announces Second Investiga-tion into Texas Hospital for Potentially Unlawfully Performing "Gender Transitioning" Procedures*, Ken Paxton Atty. Gen. of Tex. (May 19, 2023), https://www.texasattorneygeneral.gov/news/releases/paxton-announces-second-investigation-texas-hospital-potentially-unlawfully-performing-gender.

Procedures and Treatments") mirror the statutory language of SB14, even though at the time, the bill was still being debated at the Texas Legislature. The OAG further sought records with the terms "gender affirmation process," "social affirmation," "gender-affirming surgeries," and "gender dysphoria."[36]

70. These ongoing legislative and executive actions by Texas officials underscore the true motivations underlying the Ban: SB14 has nothing to do with protecting children and everything to do with expressing disapproval of, and stigmatizing, transgender people. These actions also make clear that the Texas officials stand ready to use the full scope of their authority to enforce SB14.

VI. THE IMPACT OF THE BAN ON PLAINTIFFS

A. The Impact of the Ban on Plaintiff Families

71. SB14 threatens the health and wellbeing of Luna Loe, Maeve Moe, Nathan Noe, Samantha Soe, and Grayson Goe, who have been thriving with their families' loving support and, for the four minors who have reached adolescence, medical care to treat their gender dysphoria.

1. The Loe Family

72. Plaintiff Lazaro Loe is the father of Luna Loe, a twelve-year-old transgender girl. Declaration of Lazaro Loe, attached hereto as Ex. 1, ¶¶ 1–33.[37] Lazaro and Luna are Hispanic/Latino. *Id*. ¶ 4. They were both born in Texas, and Luna has lived in Texas her entire life. *Id*. ¶¶ 7–8. They live in Bexar County. *Id*. ¶ 2.

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[36] *Id.*

[37] Plaintiffs incorporate the Declaration of Lazaro Loe by reference as though fully set forth herein.

73. Luna has always known she was a girl and expressed her female gender identity from a very early age. *Id*. ¶¶ 10–11. By the time she was five or six, her friends naturally started using female pronouns for her and she went by female nicknames. *Id*. ¶ 11. Many of her friends have consistently known her as a girl since kindergarten. *Id*. ¶ 14. By Luna's fourth-grade year, she started asking everyone she knew to only use she/her/hers pronouns and refer to her by her chosen female name. *Id*.

74. Being fully herself in all areas of her life has allowed Luna to thrive, even during the COVID-19 pandemic. *Id*. ¶ 15. Luna has seen a child psychologist since she was six years old and was diagnosed with gender dysphoria. *Id*. ¶ 16. She does not want to go through puberty in a gender that she is not and cannot fathom that happening. *Id*. ¶ 18. Her parents took her to a clinic to see a pediatric endocrinologist, who determined that puberty blockers would be medically necessary to treat Luna's gender dysphoria. *Id.* ¶ 18. After speaking with the doctor about possible benefits and side effects, Luna and her parents collectively decided that puberty blockers would be beneficial and necessary for her. *Id.*

75. Luna has now been on puberty blockers for a little over a year and they have had a hugely positive effect on her life. *Id.* ¶ 20. She enjoys swimming, art, piano, theater, and tennis, and she has a thriving social life. *Id.* ¶ 26.

76. SB14 threatens to upend Luna's life and deprive her of medically necessary treatment that has helped her thrive. *Id.* ¶¶ 28, 31. If SB14 goes into effect, the Loe family may be forced to move away from Texas—the only home that Luna has ever known. *Id.* at ¶¶ 27, 32.

2. The Moe Family

77. Plaintiffs Matthew and Mary Moe are the parents of Maeve Moe, a nine-year-old transgender girl who has lived in Texas all her life. Mary Moe Decl., attached hereto as Ex. 2, ¶¶ 1–20; Matthew Moe Decl., attached hereto as Ex. 3, ¶¶ 1–14.[38]

78. Maeve has always known she is a girl and expressed it almost as soon as she could speak, only feeling comfortable wearing girls' clothes. Mary Moe Decl. ¶¶ 5–7; Matthew Moe Decl. ¶ 6. At first, Matthew and Mary only allowed Maeve to wear boys' clothes outside of the house, but they saw how upsetting it was for her and eventually let Maeve wear girls' clothes outside the house. Mary Moe Decl. ¶ 7; Matthew Moe Decl. ¶ 6.

79. When she was five years old, Mary took Maeve to see a licensed professional counselor, who recommended that Matthew and Mary affirm Maeve's gender identity to support her mental health and wellbeing. Mary Moe Decl. ¶ 8; Matthew Moe Decl. ¶ 7. Maeve's primary care provider agreed and supported her name change. Mary Moe Decl. ¶ 9. Maeve's parents began to use "she" pronouns and had her name legally changed before she began kindergarten. Mary Moe Decl. ¶¶ 8, 10; Matthew Moe Decl. ¶¶ 7–8. Maeve entered kindergarten as the girl she knows herself to be, and has thrived throughout elementary school, making friends and excelling academically, with a particular passion for geography. Mary Moe Decl. ¶¶ 4, 10, 12; Matthew Moe Decl. ¶ 8.

80. When Maeve was six, she saw an endocrinologist, and she has returned for follow-up visits every year since. Mary Moe Decl. ¶ 11; Matthew Moe Decl. ¶ 9. The endocrinologist diagnosed Maeve with gender dysphoria and has told Maeve's parents that, now that Maeve is

[38] Plaintiffs incorporate the Declaration of Mary Moe and the Declaration of Matthew Moe by reference as though fully set forth herein.

nine, it may only be a matter of months before puberty begins. Mary Moe Decl. ¶¶ 11, 13; Matthew Moe Decl. ¶ 10. Maeve has lived openly as a girl since she was four years old and finds the idea of her body changing, in ways that do not match the girl she knows herself to be, extremely upsetting. Mary Moe Decl. ¶¶ 15–16. Matthew and Mary have discussed the risks and benefits of puberty blockers, considered the advice of medical professionals, and know that Maeve getting a puberty blocker is the best decision to keep their child healthy. Mary Moe Decl. ¶ 11; Matthew Moe Decl. ¶¶ 9, 11.

81. Matthew and Mary have seen how destabilizing it is for Maeve when she is unable to be herself, and they know that SB14 could make it difficult for her to access the treatment she needs to do so. Mary Moe Decl. ¶¶ 15–17; Matthew Moe Decl. ¶¶ 12–13. To ensure their child's safe access to medical treatment, Mary is temporarily moving with Maeve and her sibling to another state, while Matthew will stay behind in their Texas home in Montgomery County. Mary Moe Decl. ¶¶ 18–20; Matthew Moe Decl. ¶¶ 2, 13–14. Mary is heartbroken that she must move her children away from their home and father, even temporarily, and Matthew will miss his family very much, but both know that they must take these drastic measures to keep their daughter healthy and safe. Mary Moe Decl. ¶¶ 19–20; Matthew Moe Decl. ¶¶ 13–14. They hope SB14 is struck down so their family can soon be reunited in Texas. Mary Moe Decl. ¶ 20; Matthew Moe Decl. ¶ 14.

3. The Noe Family

82. Plaintiff Nora Noe is the mother of Nathan Noe, a sixteen-year-old transgender boy. Nora Noe Declaration, attached hereto as Ex. 4, ¶¶ 1–21.[39] Nathan lives in Williamson County with his parents and two younger siblings.

83. Before starting testosterone, Nathan suffered from severe anxiety and had symptoms of obsessive-compulsive disorder. *Id*. ¶ 6. Though he had been a happy and gifted child, Nathan's mother, Nora, noticed a dramatic change in his personality around age eleven. *Id*. ¶¶ 5–6. Nathan became withdrawn, and his grades fell to the point that his parents decided to homeschool him because he could not participate in online school during the COVID-19 pandemic. *Id.* ¶¶ 6–7. The worst came around Nathan's thirteenth birthday, when he started menstruating. Having his period was so distressing to Nathan that he would barely leave his room, and when he did, he would curl up on a couch looking "haunted and empty." *Id.* ¶ 8.

84. A few months later, Nathan came out as transgender. Nora was shocked at first but also knew immediately that Nathan needed specialized medical and mental health care. *Id.* ¶¶ 9–10. Nora and her husband agreed that, as with any medical issue, they would proceed with caution and make sure that they fully understood every step along the way. *Id.* ¶ 11. They took Nathan to his family doctor, who diagnosed him with gender dysphoria, to an OBGYN who prescribed birth control pills to stop his menstruation, to a therapist specializing in adolescent gender dysphoria, and eventually to a doctor with expertise in medical treatment for gender dysphoria. *Id.* ¶¶ 12, 14. Under that doctor's care, Nathan started taking testosterone in November 2021. *Id*. ¶ 15.

[39] Plaintiffs incorporate the Declaration of Nora Noe by reference as though fully set forth herein.

85. Being on testosterone has transformed Nathan's life: he has regained interest in activities he loves, like singing and swimming; he has a newfound confidence that enables him to form and maintain healthy relationships; and he is excelling in school again. *Id*.

86. News of SB14's consideration and passage has already impacted the Noe family. Nathan's concern about the law has made it more difficult for him to focus on school, and his younger siblings are frightened about what could happen to their family. *Id*. ¶ 17. Nathan's previously scheduled consultation for chest surgery, which Nora, Nathan, and Nathan's father had been discussing, and which Nathan's doctor recommended as treatment to further alleviate his gender dysphoria, was cancelled in anticipation of SB14 taking effect. *Id*. ¶ 18. If SB14 does take effect, Nora and Nathan will be forced to travel out of state for Nathan's medical treatment for his gender dysphoria, missing work and school, bearing the expense of travel, and leaving Nora's husband to care for their two younger children and Nora's elderly mother. *Id.* ¶ 19. But Nora says there would be no other option: the Noe family loves Texas and does not want to leave, and she cannot allow Nathan to lose the ground he has gained—emotionally, socially, and academically—since starting testosterone. *Id.* ¶¶ 20–21.

4. The Soe Family

87. Plaintiffs Sarah and Steven Soe are the loving parents of Samantha Soe, a resilient and confident fifteen-year-old transgender girl. Sarah Soe Decl., attached hereto as Ex. 5, ¶¶ 1–20; Steven Soe Decl., attached hereto as Ex. 6, ¶¶ 1–20.[40] They live in Hays County. Sarah Soe Decl. ¶ 4.

[40] Plaintiffs incorporate the Declaration of Sarah Soe and the Declaration of Steven Soe by reference as though fully set forth herein.

88. Samantha loves choir, theater, geography, music, video games, and sports, though she no longer competes on school sports teams due to Texas's law barring transgender athletes from participating in sports in accordance with their gender identity. Sarah Soe Decl. ¶¶ 5–11; Steven Soe Decl. ¶¶ 5–11.

89. Sarah and Steven are both educators who have raised their children to be kind and intelligent people. Sarah Soe Decl. ¶ 20; Steven Soe Decl. ¶ 20. The most important thing in the world for them is to protect their children. Sarah Soe Decl. ¶¶ 9, 20; Steven Soe Decl. ¶¶ 9, 20.

90. Samantha told her parents that she was transgender when she was about twelve years old. Sarah Soe Decl. ¶ 8; Steven Soe Decl. ¶ 8. Samantha never fit stereotypical male gender norms, and as she neared puberty, she became noticeably uncomfortable with being treated as a boy. Sarah Soe Decl. ¶ 10; Steven Soe Decl. ¶ 10.

91. When Samantha was about thirteen years old, her mother asked her pediatrician for a referral, and they went to a pediatric endocrinologist, who diagnosed Samantha with gender dysphoria. Sarah Soe Decl. ¶¶ 13–14; Steven Soe Decl. ¶¶ 13–14. After the pediatric endocrinologist explained all the risks and benefits of the available medical treatment and their own thorough research (including speaking with multiple doctors), Sarah and Steven decided that the benefits of this treatment outweighed the potential risks. Sarah Soe Decl. ¶¶ 14–16; Steven Soe Decl. ¶¶ 14–15. Samantha first received puberty blockers, and estradiol the next year, which she has been taking since December 2022. Sarah Soe Decl. ¶ 14; Steven Soe Decl. ¶ 13. Samantha's mental health has improved significantly, and the prospect of having to stop this treatment is terrifying and upsetting. Sarah Soe Decl. ¶¶ 12, 17, 19; Steven Soe Decl. ¶ 16.

92. Because of SB14, the Soe family is considering whether and how to get Samantha treatment out of state, which would either require them to split up their family or spend thousands

of dollars on out-of-pocket medical treatment and travel, when they are already facing the loss of insurance coverage under Sarah and Steven's state employees' health plan for that treatment. Sarah Soe Decl. ¶¶ 18–20; Steven Soe Decl. ¶¶ 18–20.

5. The Goe Family

93. Plaintiff Gina Goe is the mother of Grayson Goe, a fifteen-year-old transgender boy; they both live in McLennan County. Gina Goe Decl., attached hereto as Ex. 7, ¶¶ 1–23.[41]

94. Grayson was assigned female at birth, but just before he turned twelve years old, he told his mother that he was a boy, something he had known for a while. *Id*. ¶ 9.

95. Prior to coming out as transgender, Grayson experienced extreme emotional distress for many years, including incidents of self-harm, some of which required emergency medical care. *Id*. ¶¶ 10–11. Gina took her son to see an adolescent medicine doctor in 2020, who ultimately diagnosed him with gender dysphoria. *Id*. ¶¶ 13–14. Grayson used a binder to make his chest appear more masculine, and he was prescribed birth control to stop his period. *Id*. ¶¶ 15–16.

96. When Grayson turned fifteen, he was evaluated for hormone therapy, and after a comprehensive review of all the possible side effects and benefits with the medical provider, Gina made the informed decision (with Grayson's assent) to begin testosterone. *Id.* ¶¶ 16–18. Since starting testosterone in April 2023, Gina has seen a massive positive change in Grayson as his gender dysphoria has started to alleviate. *Id.* ¶ 19.

97. Being forced to stop this medical treatment would be devastating to Grayson, and Gina is extremely concerned about the ramifications to Grayson's mental health should he no longer be able to access treatment for his gender dysphoria. *Id.* ¶¶ 20, 23.

[41] Plaintiffs incorporate the Declaration of Gina Goe by reference as though fully set forth herein.

B. The Impact of the Ban on Physician Plaintiffs

1. Dr. Richard Ogden Roberts III

98. Plaintiff Richard Ogden Roberts III, M.D., M.P.H., a member of GLMA, is a pediatric endocrinologist at Texas Children's Hospital in Houston, Texas. Affidavit of Richard Ogden Roberts III, M.D., attached hereto as Ex. 8, ¶¶ 4, 5, 9.[42] Dr. Roberts is suing on behalf of himself and his transgender adolescent patients. *Id.* ¶ 3. Dr. Roberts joined the faculty at Baylor College of Medicine and Texas Children's Hospital in 2020. *Id*. ¶¶ 10, 13. Dr. Roberts serves as Division of Endocrinology Transgender Care Co-Lead, and since 2023, as the co-Medical Director of the Transgender Care Program at Texas Children's Hospital. *Id*. ¶ 13.

99. As a pediatric endocrinologist, Dr. Roberts provides evidence-based medical care as treatment for gender dysphoria, including puberty-delaying medications and hormones, which is informed by widely accepted clinical practice guidelines such as the WPATH Standards of Care and the Endocrine Society Clinical Guidelines. *Id.* ¶¶ 14, 17–18. Dr. Roberts considers medical treatment for gender dysphoria to be evidence-based, safe, and effective. *Id.* ¶ 32. In fact, he provides the same treatments to other patients to treat other health conditions. *Id.* ¶¶ 23–24.

100. Dr. Roberts considers SB14 to be in direct conflict with the oath he swore as a physician and with many of the rules, regulations, and statutes that he is required to follow. *Id.* ¶¶ 31–32. If SB14 takes effect, Dr. Roberts will be required to either fully comply with the Ban and therefore be unable to provide his transgender adolescent patients with the medical treatment they need, in violation of the oath he took as a physician, or to risk losing his medical license and facing other discipline for providing his patients with the medical treatment that they need. *Id.* ¶¶ 28, 31.

[42] Plaintiffs incorporate the Affidavit of Richard Ogden Roberts III, M.D. by reference as though fully set forth herein.

In addition, Dr. Roberts fears that by prohibiting the provision of medical treatment for gender dysphoria for his transgender adolescent patients, and coverage thereof for his patients on Medicaid or CHIP, SB14 will negatively impact the mental health and wellbeing of his patients by, for example, leading to worsening depression, increased anxiety, and possibly suicidal ideation. *Id.* ¶¶ 34, 36. Dr. Roberts is gravely concerned about his patients' ability to survive, much less thrive, if SB14 takes effect. *Id.* ¶ 34.

2. Dr. David Leo Paul

101. Plaintiff David Leo Paul, M.D., a member of GLMA, is a pediatric endocrinologist in Houston, Texas. Affidavit of David Leo Paul, M.D., attached hereto as Ex. 9, ¶¶ 4–5, 8.[43] Dr. Paul is suing on behalf of himself and his transgender adolescent patients. *Id.* ¶ 3. After a 28-year career in the U.S. Air Force, Dr. Paul joined the faculty at Baylor College of Medicine and Texas Children's Hospital in 2012. *Id.* ¶¶ 9–14.

102. Dr. Paul provides medical treatment for gender dysphoria, including puberty-delaying treatment and hormone therapy, to transgender adolescents in Texas in line with the WPATH Standards of Care and the Endocrine Society Clinical Guidelines. *Id*. ¶¶ 16–19. Dr. Paul understands these treatments to be "standard medicine," in large part because he provides the very same treatments to cisgender patients who have various conditions related to abnormal puberty. *Id*. ¶¶ 11, 20.

103. If SB14 is allowed to go into effect, Dr. Paul will face the impossible decision to either violate his oath as a physician by disregarding his patients' medical needs and inflicting needless suffering, or violate the law, putting his medical license and his livelihood at risk. *Id*. ¶

[43] Plaintiffs incorporate the Affidavit of David Leo Paul, M.D. by reference as though fully set forth herein.

21. If his adolescent patients were to lose access to medical treatment for gender dysphoria, regardless of whether they "wean off" their medications, Dr. Paul fears that his patients would backslide on the progress he has routinely seen them make in their mental health, quality of life, and academic performance. *Id.* ¶¶ 23–24.

3. Dr. Patrick W. O'Malley

104. Plaintiff Patrick W. O'Malley, M.D., M.P.H., a member of GLMA, is a psychiatrist specializing in children and adolescents at Texas Children's Hospital, where he runs the Intensive Outpatient Program, and Baylor College of Medicine, where he teaches general psychiatry and child psychiatry. Affidavit of Patrick O'Malley, M.D., M.P.H., attached hereto as Ex. 10, ¶¶ 6–7.[44] Dr. O'Malley is suing on behalf of himself and his transgender adolescent patients. *Id*. ¶ 3.

105. Approximately 20% of Dr. O'Malley's practice involves treating minors with gender dysphoria, including psychotherapy, psychiatric medication management, and family consultation. *Id*. ¶ 11. As a psychiatrist, Dr. O'Malley regularly works in a multidisciplinary manner with colleagues, both within and outside Texas Children's Hospital, who provide medical treatment for gender dysphoria such as puberty-delaying medications and hormones. *Id*. ¶ 15. As such, and among other things, Dr. O'Malley makes assessments, provides consultations, and, if necessary, writes assessment letters documenting a patient's gender dysphoria and suitability for medical treatment for gender dysphoria if required by the patient's insurance or medical provider. *Id.*

106. Because SB14 prohibits a physician or other healthcare provider receiving state public funding from facilitating the provision of medical treatment for gender dysphoria for

[44] Plaintiffs incorporate the Affidavit of Patrick W. O'Malley, M.D., M.P.H. by reference as though fully set forth herein.

adolescents, if SB14 were allowed to take effect, Dr. O'Malley would be incapable of providing his adolescent patients with gender dysphoria with the treatment they need as he would be barred from working collaboratively with other providers to effectively manage and treat an adolescent's gender dysphoria. *Id*. ¶ 19.

107. If SB14 is allowed to take effect, Dr. O'Malley knows that his patients' mental health will suffer, and because his patients have the most acute mental health symptoms, he fears that he will be forced to witness their decline, up to and including their death. *Id*. ¶¶ 21–24. Dr. O'Malley also fears that SB14 will exacerbate health disparities for his patients who receive coverage through Medicaid and CHIP who will lose that coverage if SB14 goes into effect. *Id.* ¶ 25.

C. The Impact of the Ban on the Members of Organizational Plaintiffs

1. PFLAG

108. Founded in 1973, Plaintiff PFLAG is the first and largest organization for LGBTQ+ people, their parents and families, and allies. A 501(c)(3) nonprofit membership organization, PFLAG's mission is "to create a caring, just, and affirming world for LGBTQ+ people and those who love them." PFLAG has chapters in 49 states and the District of Columbia. Affidavit of Brian K. Bond, attached hereto as Ex. 11, ¶¶ 2-3,7.[45]

109. Supporting LGBTQ+ young people and strengthening their families has been central to PFLAG's work since its founding, and that objective includes encouraging and supporting parents and families of transgender and gender expansive people in affirming their children and helping them access the social, psychological, and medical supports they need. *Id*. ¶¶ 4-5.

[45] Plaintiffs incorporate the Affidavit of Brian K. Bond by reference as though fully set forth herein.

110. PFLAG carries out that commitment through supporting the development and work of the PFLAG Chapter Network, engaging in policy advocacy for equitable and protective laws and policies, forming coalitions with organizations who share PFLAG's goals, developing trainings and educational materials, and engaging with the media. More specifically, it includes working with PFLAG families to encourage love for and support of their transgender and gender expansive children and to help them ensure that their children's needs are met. *Id.* ¶¶ 10, 18-19.

111. PFLAG has 18 chapters across the State of Texas with nearly 1,500 members. Those members include families with transgender youth who currently are or soon will be receiving the medical care SB14 prohibits as part of a prescribed course of care for gender dysphoria, including the Plaintiff Loe, Moe, Noe, Soe, and Goe families. *Id*. ¶¶ 7, 11; Lazaro Loe Decl. ¶3; Mary Moe Decl. ¶ 3; Matthew Moe Decl. ¶ 3; Nora Noe Decl. ¶ 3; Sara Soe Decl ¶ 3; Steven Soe Decl. ¶ 3; Gina Goe Decl. ¶ 3.

112. SB14's passage had a dramatic impact on PFLAG families, who began seeking support and resources from their PFLAG chapters, making contingency plans for how to access medical care outside Texas, and pursuing mental health support for the fear, distress, and anxiety they and their children are experiencing at the prospect of being denied this medically necessary care. Some families are already feeling the effects of SB14, as their appointments for scheduled care are being cancelled or they are losing access to medical providers who are leaving Texas. Bond Aff. ¶¶ 13-14.

113. If SB14 is allowed to become effective, the harms will be even more widespread for PFLAG families, who will lose the ability to make medical decisions for their children, lose access to medical treatments their children need solely because they are treatments for gender dysphoria, and lose coverage for care that has been previously paid for under state-funded health

plans. SB14 will put PFLAG families with the resources to do so in the impossible situation of having to flee Texas, split up their family, or travel regularly out of state to obtain medical care. For the vast majority of PFLAG families, however, those costs are too high. SB 14 will force PFLAG families to stop providing the medical care that has helped their transgender children thrive, putting those children at risk of the very serious mental and physical harm those families sought medical care for in the first place. *Id.* ¶¶ 13, 15-16.

2. GLMA

114. Founded in 1981, GLMA is the world's largest and oldest association of LGBTQ+ healthcare professionals. Affidavit of Alex Sheldon, attached hereto as Ex. 12, ¶ 7.[46]

115. GLMA is a 501(c)(3) nonprofit membership organization whose mission is to ensure health equity for LGBTQ+ individuals and equality for LGBTQ+ health professionals in their work and learning environments. *Id*. ¶ 7. GLMA seeks to achieve this mission by utilizing the scientific expertise of its diverse, multidisciplinary membership to inform and drive advocacy, education, and research. *Id*.

116. GLMA's membership includes approximately 1,000 member physicians, nurses, advanced practice nurses, physician assistants, researchers and academics, behavioral health specialists, health profession students, and other health professionals. *Id*. ¶ 10. GLMA's members reside and work across the United States, including Texas, and in several other countries. *Id*. Their practices represent the major health care disciplines and a wide range of health specialties, including endocrinology, internal medicine, family practice, psychiatry, obstetrics/gynecology, emergency medicine, neurology, and infectious diseases. *Id*.

[46] Plaintiffs incorporate the Affidavit of Alex Sheldon by reference as though fully set forth herein.

117. As part of its mission to ensure health equity for the LGBTQ+ community as well as equality for LGBTQ+ health professionals, GLMA is committed to breaking down barriers to comprehensive medical care for the LGBTQ+ community. *Id*. ¶ 15. This includes GLMA's steadfast commitment to ensure that transgender individuals receive the medical treatment for gender dysphoria they want, need, and deserve. *Id*.

118. As such, GLMA adopted in 2018, and later affirmed in 2021, a formal policy statement on "Transgender Healthcare," which states that therapeutic treatments such as hormone therapy and gender-affirming surgeries are medically necessary for the purpose of treatment of gender dysphoria and that they should be covered by all public and private insurance plans. *Id*. ¶ 16. In addition, in 2019, in conjunction with the American Medical Association, GLMA published an issue brief titled "Health insurance coverage for gender-affirming care of transgender patients," which discusses both the positive effects and outcomes of gender-affirming medical care for transgender patients, as well as the negative effects and serious health consequences that transgender patients face when they are denied access to medically indicated treatment for gender dysphoria. *Id*. ¶ 17.

119. GLMA considers laws like SB14 an affront to healthcare ethics and the principles of equality and inclusivity that should govern healthcare practices. *Id*. ¶ 22. GLMA's members and their patients stand to be negatively affected by SB14. *Id*. ¶ 22. SB14 places GLMA's health professional members in the untenable position of choosing to comply with SB14 and endangering the health and wellbeing of their transgender adolescent patients or to follow their medical or professional best judgment and duty to their patients and violate SB14 by providing their adolescent patients with the best care and the care they need. *Id*. ¶ 23. This negative impact to GLMA's members includes Plaintiffs Dr. Roberts, Dr. Paul, and Dr. O'Malley as well as

declarants Dr. Cooper and Dr. Koe, all of whom are GLMA members living and practicing medicine in Texas. Roberts Aff. ¶¶ 4-5; Paul Aff. ¶¶ 4-5; O'Malley Aff. ¶¶ 4-5; Aff. of M. Brett Cooper, M.D, attached hereto as Ex. 13, ¶¶ 3, 6; Decl. of Kathryn Koe, D.O., attached hereto as Ex. 14, ¶¶ 4, 7.[47] For GLMA's physician members, SB14 also mandates the revocation or denial of licensure to any physician who provides medical treatment for gender dysphoria to adolescents and threatens additional disciplinary actions. Sheldon Aff. ¶ 24.

VII. THE TEXAS CONSTITUTION PROTECTS PARENTS, TRANGENDER YOUTH, AND MEDICAL PROVIDERS FROM STATE DEPRIVATION OF THEIR RIGHTS.

A. Parents of Transgender Youth Have Fundamental Rights Under the Texas Constitution.

120. The Texas Constitution guarantees its citizens certain fundamental rights, specifically: "[n]o citizen of this State shall be deprived of life, liberty, property, privileges, or immunities, or in any manner disfranchised, except by the due course of the law of the land." Tex. Const. art. I, § 19. This guarantee includes the fundamental rights of parents with regard to their children. *Wiley v. Spratlan*, 543 S.W.2d 349, 352 (Tex. 1976).

121. Under Texas law, "[i]t is axiomatic that parents enjoy a fundamental right to the care, custody, and control of their children . . . This right includes the right of parents to give, withhold, and withdraw consent to medical treatment for their children." *T.L. v. Cook Children's Med. Ctr.,* 607 S.W.3d 9, 43 (Tex. App.—Fort Worth 2020, pet. denied). Texas law recognizes that "parents are presumed to be appropriate decision-makers, giving parents the right to consent to their [child's] medical care[.]" *Miller ex rel. Miller v. HCA, Inc.*, 118 S.W.3d 758, 766 (Tex. 2003). Parents have not only a natural right but a "'high duty' to recognize symptoms of illness

[47] Plaintiffs incorporate the Affidavit of M. Brett Cooper, M.D. and the Declaration of Kathryn Koe, D.O. by reference as though fully set forth herein.

and to seek and follow medical advice" for their child. *Parham v. J.R.*, 442 U.S. 584, 602 (1979); *see also* Tex. Fam. Code § 151.001(a)(3) (parents have the right and duty "to support the child, including providing the child with . . . medical and dental care").

122. Parents do not sacrifice these rights simply because their children are transgender. When a parent provides informed consent, the adolescent assents, and a physician recommends a medically necessary course of treatment that is safe and effective for the adolescent patient, the parent's fundamental right to make medical care decisions for their adolescent is at its apex. *See Brandt v. Rutledge*, No. 4:21-CV-00450, 2023 WL 4073727, at *36 (E.D. Ark. June 20, 2023) (parents of transgender children "have a fundamental right to seek medical care for their children and, in conjunction with their adolescent child's consent and their doctor's recommendation, make a judgment that medical care is necessary").

123. SB14 infringes on those fundamental rights by prohibiting, penalizing, and denying coverage for the provision of the very medical treatment parents seek for their children with gender dysphoria—treatment that their transgender children want and that their children's doctors and medical providers have prescribed as medically necessary in accordance with established standards of care. *See, e.g.*, *Brandt v. Rutledge*, 2023 WL 4073727, at *36; *Doe v. Ladapo*, No. 4:23-CV-114, 2023 WL 3833848, at *11 (N.D. Fla. June 6, 2023); *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1144–45 (M.D. Ala. 2022) (holding that parents were likely to show that a bill prohibiting "medications to treat gender dysphoria in minors, even at the independent recommendation of a licensed pediatrician . . . infringes on their fundamental right to treat their children with transitioning medications subject to medically accepted standards").

124. Preventing Parent Plaintiffs and PFLAG's parent members from making medical care decisions concerning the care, custody, and control of their children violates the fundamental

right to parental autonomy guaranteed by Due Course of Law under the Texas Constitution and cannot survive strict scrutiny.

B. The Ban Classifies and Discriminates Unconstitutionally Based on Sex and Transgender Status.

125. Under the Texas Constitution, all persons "have equal rights," Tex. Const. art. 1, § 3, and "[e]quality under the law shall not be denied or abridged because of sex." *Id.*, art. 1, § 3a. SB14 runs afoul of both equality guarantees because it classifies and discriminates based on both sex and transgender status.

126. The Ban draws a classification based on sex in three distinct ways. First, the Ban speaks in explicitly gendered terms and facially discriminates based on sex. Second, the Ban discriminates based on sex stereotypes relating to a person's sex assigned at birth. Third, the Ban discriminates based on sex because it discriminates based on transgender status.

127. If the legislature cannot "writ[e] out instructions" for determining whether treatment is permitted "without using the words man, woman, or sex (or some synonym)," the law classifies based on sex. *Bostock v. Clayton Cnty*., 140 S. Ct. 1731, 1746 (2020).

128. The Ban prohibits medically necessary treatment when the treatment is provided in a manner the State deems "inconsistent with the minor's biological sex." SB14 § 2 (proposed Tex. Health & Safety Code § 161.702). If one must know the sex of a person to know whether or how a provision applies to the person, the provision draws a line based on sex.

129. Here, "[t]o know whether treatment with any of these medications is legal, one must know whether the patient is transgender. And to know whether treatment with testosterone or estrogen is legal, one must know the patient's natal sex." *Doe v. Ladapo*, No. 4:23CV114-RH-MAF, 2023 WL 3833848, at *10 (N.D. Fla. June 6, 2023); *see also Brandt by & through Brandt v. Rutledge,* 47 F.4th 661, 669 (8th Cir. 2022) (ban on medical treatment for gender dysphoria for

adolescents "discriminates on the basis of sex" insofar as "the minor's sex at birth determines whether or not the minor can receive certain types of medical care"); *Dekker v. Weida*, No. 4:22CV325-RH-MAF, 2023 WL 4102243, at *13 (N.D. Fla. June 21, 2023). By "discriminating against transgender persons," the Ban "unavoidably discriminates against persons with one sex identified at birth and another today." *Bostock*, 140 S. Ct. at 1746.

130. The Ban further discriminates based on sex by allowing medical interventions that reinforce sex stereotypes, but "tether[ing] plaintiffs to sex stereotypes which, as a matter of medical necessity, they seek to reject." *Kadel v. Folwell*, 446 F. Supp. 3d 1, 14 (M.D.N.C. 2020), *aff'd*, 12 F.4th 422 (4th Cir. 2021), *cert. denied*, 142 S. Ct. 861 (2022).

131. SB14 allows medical procedures and treatments to persons with "disorder[s] of sex development" for the purpose of aligning the patient's body with sex stereotypes, while denying the exact same services to transgender persons because as "transgender individual[s they do] not conform to the sex-based stereotypes of the sex . . . assigned at birth." *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1048 (7th Cir. 2017); *accord Glenn v. Brumby*, 663 F.3d 1312, 1316 (11th Cir. 2011).

132. The Ban explicitly prohibits masculinizing or feminizing procedures when different from the sex assigned at birth. *See* SB14 § 2 (proposed Tex. Health & Safety Code § 161.702) ("if that perception is *inconsistent* with the child's biological sex") (emphasis added).

133. Permitting interventions to reinforce sex stereotypes while prohibiting the same interventions for challenging them constitutes sex discrimination.

134. By allowing and disallowing medical treatment based on sex designated at birth, the Ban is an impermissible "form of sex stereotyping where an individual is required effectively

to maintain [their] natal sex characteristics." *Boyden v. Conlin*, 341 F. Supp. 3d 979, 997 (W.D. Wis. 2018).

135. Lastly, as the United States Supreme Court explained in *Bostock v. Clayton County*, "it is impossible to discriminate against a person for being . . . transgender without discriminating against that individual based on sex." 140 S. Ct. at 1741. In other words, "discrimination based on . . . transgender status necessarily entails discrimination based on sex." *Id*. at 1747; *cf. Tarrant Cnty. Coll. Dist. v. Sims*, 621 S.W.3d 323, 329 (Tex. App.—Dallas 2021, no pet.) ("[W]e must follow *Bostock* and read the [Texas Commission on Human Rights Act's] prohibition on discrimination 'because of . . . sex' as prohibiting discrimination based on an individual's status as a . . . transgender person.").

136. SB14's discrimination based on transgender status not only classifies based on sex, but also violates Tex. Const. art. 1, § 3's guarantee of equal rights independently. Classifications based on transgender status are suspect and warrant strict or heightened scrutiny because (1) transgender people have suffered a long history of discrimination in Texas and across the country and continue to suffer such discrimination to this day; (2) transgender people are a discrete and insular group and lack the political power to protect their rights through the legislative process; (3) a person's transgender status bears no relation to their ability to contribute to society; and (4) gender identity is a core, defining trait so fundamental to one's identity and conscience that a person cannot be required to abandon it as a condition of equal treatment. *See In re H.Y.*, 512 S.W.3d 467, 478 (Tex. App.—Houston [1st Dist.] 2016, pet. denied).

137. The overwhelming majority of courts to consider the question have found that transgender people constitute a quasi-suspect class. *See Grimm v. Gloucester Cnty. Sch. Bd.,* 972 F.3d 586, 607 (4th Cir. 2020), as amended (Aug. 28, 2020); *see also Karnoski v. Trump*, 926 F.3d

1180, 1200 (9th Cir. 2019); *Dekker*, 2023 WL 4102243 at *12–13; *Brandt*, 2023 WL 4073727 at *31 (E.D. Ark. June 20, 2023); *Ladapo*, 2023 WL 3833848 at *9 (N.D. Fla. June 6, 2023); *Ray v. McCloud*, 507 F. Supp. 3d 925, 937–38 (S.D. Ohio 2020); *M.A.B. v. Bd. of Educ. of Talbot Cnty.*, 286 F. Supp. 3d 704, 719–20 (D. Md. 2018); *Flack v. Wis. Dep't of Health Servs*., 328 F. Supp. 3d 931, 952–53 (W.D. Wis. 2018); *F.V. v. Barron*, 286 F. Supp. 3d 1131, 1145 (D. Idaho 2018); *Evancho v. Pine-Richland Sch. Dist.,* 237 F. Supp. 3d 267, 288 (W.D. Pa. 2017); *Bd. of Educ. of the Highland Loc. Sch. Dist. v. U.S. Dep't of Educ*., 208 F. Supp. 3d 850, 873 (S.D. Ohio 2016); *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015); *Adkins v. City of New York*, 143 F. Supp. 3d 134, 139 (S.D.N.Y. 2015); *cf. Brandt*, 47 F.4th at 670 n.4.

138. SB14 expressly and exclusively targets transgender adolescents by prohibiting medical treatments based on whether they "attempt[] to affirm the minor's perception of his or her gender or biological sex, if that perception is inconsistent with the minor's biological sex." SB14 § 2 (proposed Tex. Health & Safety Code § 161.702); *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1147 (M.D. Ala. 2022) (explaining that Alabama's ban on this treatment for minors "places a special burden on transgender minors because their gender identity does not match their birth sex").

139. SB14 explicitly bans "gender transitioning or gender reassignment procedures" for adolescents. By targeting "gender transition," the Ban necessarily classifies based on transgender status: it is only transgender people who undergo "gender transition" as part of treatment for gender dysphoria. And "a person cannot suffer from gender dysphoria without identifying as transgender." *Fain v. Crouch*, 618 F. Supp. 3d 313, 325 (S.D. W. Va. 2022); *see also C. P. by & through Pritchard v. Blue Cross Blue Shield of Ill*., 2022 WL 17788148, at *6 (W.D. Wash. Dec. 19, 2022); *Kadel v. Folwell*, 2022 WL 11166311, at *4 (M.D.N.C. Oct. 19, 2022); *Toomey v. Arizona*, 2019

WL 7172144, at *6 (D. Ariz. Dec. 23, 2019); *Flack v. Wis. Dep't of Health Servs*., 328 F. Supp. 3d 931, 950 (W.D. Wis. 2018). The Ban prohibits the provision of evidence-based, medically necessary treatments—including puberty-delaying treatment, hormone therapy, and reconstructive chest surgery—only when they are provided as part of treatment for gender dysphoria. They permit these same treatments for any other purpose.

140. The Ban prohibits any "physician or health care provider" from "knowingly" "provid[ing], prescribe[ing], administer[ing], or dispens[ing]" certain "procedures and treatments" to a minor "[f]or the purpose of transitioning" a minor's "biological sex as determined by the sex organs, chromosomes, and endogenous profiles" or "affirming the [minor]'s perception" of their sex "if that perception is inconsistent with the [minor]'s biological sex," or sex assigned at birth. SB14 § 2 (proposed Tex. Health & Safety Code § 161.702). Specifically, the Ban categorically bars transgender adolescents experiencing gender dysphoria from (1) specific surgical procedures "that sterilizes the child"; (2) "a mastectomy"; (3) "prescription drugs that induce transient or permanent infertility," which is defined to preclude all puberty-delaying drugs and hormone therapy; and (4) "remov[ing] any otherwise healthy or non-diseased body part or tissue." *Id*. The same services, however, may be provided to treat other conditions.

141. For example, the puberty-delaying treatment provided to transgender adolescents experiencing gender dysphoria is commonly used to treat central precocious puberty. The Ban prohibits providing puberty-delaying treatment to transgender adolescents for gender dysphoria but permits puberty-delaying treatment for central precocious puberty.

142. The Ban also prohibits hormone therapy when the treatment is used to treat transgender adolescents with gender dysphoria. But it permits the same hormone therapy when prescribed to non-transgender patients to treat other serious conditions and/or to help bring their

bodies into alignment with their cisgender gender identity. For example, cisgender boys with delayed puberty may be prescribed testosterone if they have not begun puberty by fourteen years of age. Likewise, cisgender girls with primary ovarian insufficiency, hypogonadotropic hypogonadism (delayed puberty due to lack of estrogen caused by a problem with the pituitary gland or hypothalamus), or Turner's Syndrome (a chromosomal condition that can cause a failure of ovaries to develop) may be treated with estrogen. And cisgender girls with polycystic ovarian syndrome (a condition that can cause increased testosterone and, as a result, symptoms including facial hair) may be treated with testosterone suppressants.

143. The Ban prohibits chest surgery on transgender adolescents to treat gender dysphoria, but non-transgender adolescents are permitted to undergo comparable surgeries.

C. Texas Physicians and Healthcare Providers Have Property Rights in their Medical Licenses and Liberty Rights to Engage in their Occupations.

144. The Texas Constitution guarantees that "[n]o citizen of this State shall be deprived of life, liberty, property, privileges, or immunities, or in any manner disfranchised, except by the due course of the law of the land." Tex. Const. art. I, § 19. The Ban infringes this constitutional guarantee by threatening the licenses and burdening the livelihoods of Physician Plaintiffs and GLMA members who in good faith provide medically necessary treatment to transgender youth suffering from gender dysphoria.

145. Texas law authorizes Defendant TMB to institute disciplinary and licensing proceedings against any physician who provides medical procedures or treatments prohibited by the Ban. *See, e.g.*, Tex. Occ. Code §§ 164.001, 165.001, 165.051; SB14 § 2 (proposed Tex. Occ. Code § 164.052(a)(24)). And SB14 removes any discretion by TMB regarding disciplinary sanctions because the Ban mandates that a physician who provides any prohibited medical

procedures or treatments to transgender youth have their license to practice medicine revoked. SB14 § 5 (proposed Tex. Occ. Code § 164.0552).

146. Disciplinary actions are required to be reported to the National Practitioner Data Bank[48] and may have collateral consequences on a physician's ability to practice in other states.[49] Defendant TMB, for example, requires physicians to make timely reports of any disciplinary actions taken by other jurisdictions against the physician, 22 Tex. Admin. Code § 173.3, and has taken disciplinary action against physicians based on conduct occurring in other states.[50] Upon information and belief, disciplinary sanctions may also result in loss of employment.

147. Texas physicians make a substantial investment to obtain a medical license. According to TMB, to be eligible for a physician's license in Texas, individuals must: graduate from an accredited medical school, having gained admission through a highly competitive application process which often requires incurring significant debt (in 2019, an average of between $94,399 and $142,797 for students at medical schools in Texas);[51] complete at least one continuous year of graduate medical training or a fellowship; pass rigorous state examinations; practice medicine full-time for one year; and, *inter alia*, have no relevant disciplinary or criminal history. 22 Tex. Admin. Code § 163.2.

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[48] *See* 42 U.S.C. § 11132 (requiring state medical boards to report all revocations or suspensions of physician licenses); *see also* Nat'l Practitioner Data Bank, Guidebook, at Ch. E: Reports, Table E-1 (Oct. 2018), https://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf (explaining that state medical boards and hospitals have mandatory reporting obligations).

[49] *See, e.g.*, Tex. Admin. Code § 173.3(d) (requiring reporting within 30 days of any actions issued by another state); Tex. Med. Bd. Press Release at 4-5, TMB Disciplines 27 Physicians at June Meeting, Adopts Rule Changes (June 30, 2022), https://www.tmb.state.tx.us/dl/2B28AF92-02B2-0425-2295-86E2DEAD1C51 (describing "other states' [disciplinary] actions").

[50] *Id*.

[51] *See, e.g.*, Medical School Debt Keeps Climbing, Tex. Med. Ass'n (April 2020), https://app.texmed.org/tma.archive.search/files/53049/april_20_tm_educationinfographic.pdf.

148. If physicians meet these requirements and incur the substantial associated costs, they are eligible for full licensure in Texas, for which they must apply. *Id*. §§ 163.2, 163.4. Once granted, a physician may practice medicine within Texas and has a vested property interest in their license.

149. SB14's requirement of denying or revoking a physician's license based on providing necessary medical treatment for gender dysphoria is improper interference with the physician's vested property interest in their license and cannot be justified by any legitimate state purpose, let alone a compelling one.

150. Further, prohibiting physicians and healthcare providers from providing timely and appropriate evidence-based medical care to a transgender adolescent and subjecting them to disciplinary actions and civil and other penalties for doing so is improper interference with their liberty interest in their occupation.

151. The Texas Constitution guarantees physicians and healthcare providers the right to practice their professions free from arbitrary or unduly harsh burdens. Tex. Const. art. I, § 19.

152. To fulfill this guarantee, medical providers must be able to exercise their good faith judgment in the care of their transgender adolescent patients without the State's interference in their ability to do so in accordance with well-established clinical guidelines. In fact, physicians are subject to discipline by TMB for the "failure to treat a patient according to the generally accepted standard of care." 22 Tex. Admin. Code § 190.8(1)(A); *see also Swate v. Texas Med. Bd*., No. 03-15-00815-CV, 2017 WL 3902621, at *12 (Tex. App.—Austin, Aug. 31, 2017, pet. denied) (mem. op.); *Chalifoux v. Texas State Bd. of Med. Examiners*, No. 03-05-00320-CV, 2006 WL 3196461, at *14 (Tex. App.—Austin, Nov. 1, 2006, pet. denied) (mem. op.). But SB14 demands that physicians do precisely that, interfering in the professional relationship between healthcare

providers and patients in a manner that is clearly arbitrary and so unreasonably burdensome that it is oppressive. Even for laws that only touch on economic rights, § 19 requires a rational relationship to the purpose of the law.

153. The Ban fails to comply with the Texas Constitution. The law does not serve a proper legislative purpose because, far from protecting the health and wellbeing of adolescents, the Ban harms the lives of transgender youth and their parents, without furthering the potential health and wellbeing of transgender adolescents. Texas law also demands that there be a real and substantial connection between a legislative purpose and the language of the law as it functions in practice. *See Patel v. Tex. Dep't of Licensing & Reg*., 469 S.W.3d 69, 80–81 (Tex. 2015). For SB14 and transgender youth experiencing gender dysphoria, there is none. Instead, the Ban imposes an excessive burden on physicians and healthcare providers treating such patients, relative to the Ban's purported purpose, such that the Ban is oppressive. *See id*.

D. Bans Like SB14 Have Been Enjoined Across the United States

154. Before 2021, neither Texas nor any other state prohibited the medical treatment at issue in this case. For decades, puberty blockers and hormone therapies have been prescribed to minors for a wide range of diagnoses, including for the treatment of gender dysphoria. These treatment protocols are based on evidence-based scientific research and are considered safe and effective by every major medical association, including in Texas and across the country.

155. In the summer of 2021, Arkansas became the first state to try to prohibit this medical treatment solely for transgender youth with gender dysphoria, while allowing the exact same treatment to be provided to minors with other medical diagnoses. A federal court blocked that law from taking effect in a preliminary injunction, which was upheld by the U.S. Court of Appeals for the Eighth Circuit. *Brandt*, 47 F.4th at 672. The same court has now permanently enjoined Arkansas's transgender medical treatment ban and declared it unlawful as violating the

constitutional rights of parents, minors, and healthcare providers. *Brandt*, 2023 WL 4073727, at *38 (E.D. Ark. June 20, 2023).

156. Since Arkansas attempted to ban this medical treatment for transgender youth two years ago, other states have tried to follow suit by enacting policies or legislation designed to restrict access to health care for transgender adolescents with gender dysphoria while allowing the same treatments to continue for minors with other medical diagnoses. This wave of restrictions is part of a political strategy advanced by advocacy organizations who conducted polling and found that many Americans did not understand transgender youth or the health care that they receive. Terry Schilling, the president of American Principles Project, a social conservative advocacy group, said that after the U.S. Supreme Court ruled in favor of equality for LGBTQ+ Americans, "[w]e knew we needed to find an issue that the candidates were comfortable talking about . . . And we threw everything at the wall."[52] Matt Sharp, senior counsel with Alliance Defending Freedom, explained that there is now a "sense of urgency" behind legislative attempts to ban healthcare for transgender youth across the country.[53]

157. To date, trial courts have unanimously ruled against every transgender medical care ban that has been challenged, including in Arkansas, Alabama, Florida, Indiana, Kentucky, Missouri, and Tennessee. *See L.W. by & through Williams v. Skrmetti*, No. 3:23-CV-00376, 2023 WL 4232308, at *36 (M.D. Tenn. June 28, 2023) ("To the Court's knowledge, every court to consider preliminarily enjoining a ban on gender-affirming care for minors has found that such a ban is likely unconstitutional. And at least one federal court has found such a ban to be

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[52] Adam Nagourney & Jeremy W. Peters, *How a Campaign Against Transgender Rights Mobilized Conservatives*, New York Times (Apr. 17, 2023), https://www.nytimes.com/2023/04/16/us/politics/transgender-conservative-campaign.html.

[53] *Id.*

unconstitutional at final judgment."); *Doe 1 v. Thornbury*, No. 3:23-CV-230-DJH, 2023 WL 4230481, at *1–2 (W.D. Ky. June 28, 2023) (granting preliminary injunction against Kentucky statute banning puberty blockers and hormone therapy for transgender minors); *Brandt v. Rutledge*, No. 4:21CV00450, 2023 WL 4073727, at *1–2 (E.D. Ark. June 20, 2023) (holding that Arkansas statute banning "gender transition procedures" for minors was unconstitutional after an eight-day bench trial); *K.C. v. Individual Members of Med. Licensing Bd. of Ind.,* No. 1:23-cv-00595, 2023 WL 4054086, at *1 (S.D. Ind. June 16, 2023) (granting preliminary injunction against Indiana statute banning puberty blockers and hormone therapy for transgender youth); *Doe v. Ladapo*, No. 4:23cv114-RH-MAF, 2023 WL 3833848, at *1 (N.D. Fla. June 6, 2023) (granting preliminary injunction against Florida statute and rules banning puberty blockers and hormone therapy for transgender minors); *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1137–38 (M.D. Ala. 2022) (granting preliminary injunction against Alabama statute banning puberty blockers and hormone therapy for transgender minors); *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 892–93 (E.D. Ark. 2021), *aff'd sub nom. Brandt by & through Brandt v. Rutledge*, 47 F.4th 661 (8th Cir. 2022) ("The Court finds that the Parent Plaintiffs have a fundamental right to seek medical care for their children and, in conjunction with their adolescent child's consent and their doctor's recommendation, make a judgment that medical care is necessary."), *aff'd*, 47 F.4th 661 (8th Cir. 2022); *cf. Dekker v. Weida,* No. 4:22CV325-RH-MAF, 2023 WL 4102243, at *10–11, *19 (N.D. Fla. June 21, 2023) (holding that Florida's prohibition on Medicaid coverage for treatment of gender dysphoria is unconstitutional after two-week bench trial*); Southampton Cmty. Healthcare v. Bailey*, No. 23SL-CC01673 (Mo. Cir. Ct. May 1, 2023) (granting a temporary restraining order

enjoining Missouri Attorney General's emergency rule imposing severe restrictions on the provision of medical treatment for gender dysphoria to transgender adolescents and adults).[54]

VIII. THE BAN WILL CAUSE SEVERE HARM TO TRANSGENDER ADOLESCENTS.

158. Withholding medical treatment from transgender adolescents with gender dysphoria when it is medically indicated puts them at risk of severe harm to their health and wellbeing.

159. If a medical provider is forced to stop puberty-delaying medications or hormone therapy or if state-funded healthcare plans are forced to deny coverage for them due to the Ban, the resulting loss of medical care will cause patients to begin or resume their endogenous puberty. This will result in extreme distress for patients who have been relying on medical treatments to prevent the secondary sex characteristics that come with their endogenous puberty. These bodily

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[54] On July 8, 2023, the Sixth Circuit in a split 2-1 decision after expedited review granted a stay of the preliminary injunction in *L.W.*, pertaining to Tennessee's ban. In so doing, the Sixth Circuit sharply deviated from the majority of federal courts. However, the Sixth Circuit acknowledged its views "are just that: initial" and they "may be wrong." *L.W. v. Skrmetti*, No. 23-5600, slip op. at 15 (6th Cir. July 8, 2023). Its decision is thus of little persuasive value. Indeed, the Sixth Circuit based its decision, in large part, on the notion that lack of FDA approval shows there is no medical consensus regarding this care. *Id.* at 7. But "[t]hat the FDA has not approved these drugs for treatment of gender dysphoria says precisely nothing about whether the drugs are safe and effective when used for that purpose." *Dekker*, 2023 WL 4102243, at *19. "Off-label use of drugs is commonplace and widely accepted across the medical profession." *Id.* Any "contrary implication is divorced from reality." *Id.* "Once a drug has been approved, … the drug can be distributed not just for the approved use but for any other use as well," and "[t]here ordinarily is little reason to incur the burden and expense of seeking additional FDA approval." *Id.* Indeed, Texas law explicitly recognizes the use of "off-label" medications as being permitted within the bounds of generally accepted medical practice. *See* 22 Tex. Admin. Code § 190.8(1)(K); 22 Tex. Admin. Code § 222.4(f); 28 Tex. Admin. Code § 21.3011.

Further, the Sixth Circuit's sex discrimination analysis primarily cites the U.S. Supreme Court's 1971 decision in *Reed v. Reed*, but ignores the Court's more recent declarations that "all gender-based classifications today warrant heightened scrutiny," *United States v. Virginia*, 518 U.S. 515, 555 (1996) (quotation marks omitted); *see also Sessions v. Morales-Santana*, 582 U.S. 47, 57 (2017). And that a particular court may not have recognized (to date) that classifications based on transgender status are quasi-suspect, *L.W.*, No. 23-5600, slip op. at 12, does not mean they are not. A "lack of binding precedent does not require this Court to only apply rational basis review, nor does it prevent this Court from relying on well-reasoned opinions of non-binding courts to inform its opinion." *Ray v. McCloud*, 507 F. Supp. 3d 925, 938 (S.D. Ohio 2020).

changes are extremely distressing for transgender adolescents with gender dysphoria that otherwise had been relieved by medical treatment.

160. Additionally, the effects of undergoing endogenous puberty may not be reversible even with subsequent hormone therapy and surgery in adulthood, thus exacerbating lifelong gender dysphoria in patients who have this evidence-based and medically necessary treatment withheld or withdrawn.

161. For patients currently undergoing treatment with hormones like estrogen or testosterone, withdrawing treatment can result in a range of serious physiological and mental health consequences. The body takes about six weeks to ramp up endogenous hormones. If a medical provider is forced to abruptly stop treatment, a patient will be without sufficient circulating hormones. This can result in depressed mood, hot flashes, and headaches. For patients on spironolactone—a testosterone suppressant—abruptly terminating treatment can cause a patient's blood pressure to spike, increasing an adolescent's risk of heart attack or stroke. But whether treatment is stopped abruptly or over a period of several months, the withdrawal of treatment for gender dysphoria results in predictable and negative mental-health consequences, including returned or worsening gender dysphoria and heightened anxiety and depression.

162. The Ban includes an arbitrary so-called "wean off" provision, under which an adolescent who began Prohibited Care before June 1, 2023, and "attended 12 or more sessions of mental health counseling" for "at least six months before the" course of treatment began, "shall wean off the prescription drug over a period of time and in a manner that is safe and medically appropriate." SB14 § 2 (proposed Tex. Health & Safety Code § 161.703).

163. The "wean off" provision, like the general prohibition set forth in SB14, is of little comfort to adolescent patients who have been undergoing medical treatment as of June 1, 2023.

The "wean off" provision is inconsistent with standards of care and completely arbitrary. For example, some patients for whom medical treatment for gender dysphoria is indicated and appropriate might not have "attended 12 or more sessions of mental health counseling" for "at least six months before the" course of treatment—*e.g.*, because if their mental health provider was able to make a diagnosis of gender dysphoria after fewer than 12 sessions, the patient might not have required and the provider would not have been able to bill for subsequent sessions.

164. The "wean off" provision still requires that transgender adolescents "shall wean off" the prescription drugs determined by their medical providers to be medically necessary "over a period of time." SB14 § 2 (proposed Tex. Health & Safety Code § 161.703). This provision also states that transgender adolescents "may not switch to or begin a course of treatment on another prescription drug" that falls under the Ban, thereby still prohibiting this medically necessary treatment for any transgender young person who needs it in Texas. *Id.*

165. Laws like the Ban that prohibit access to medically necessary treatment in and of themselves gravely and directly threaten the mental health and wellbeing of transgender adolescents in Texas.

166. Gender-affirming medical care can be beneficial and even lifesaving treatment for transgender adolescents experiencing gender dysphoria. The Family Plaintiffs in this action know this intimately, which is why many of them have plans to continue their child's treatment out of state, leaving their homes behind at great financial expense and at the cost of separating spouses and siblings.

167. The major medical and mental health associations in the United States support the provision of such care for the treatment of gender dysphoria. These associations include the

American Academy of Pediatrics,[55] American Medical Association,[56] the Endocrine Society,[57] the Pediatric Endocrine Society,[58] the American Psychological Association,[59] the American Academy of Family Physicians,[60] the American College of Obstetricians and Gynecologists,[61] the National Association of Social Workers,[62] and WPATH.[63]

IX. CAUSES OF ACTION

A. Declaratory Judgment – SB14 Violates the Texas Constitution and is Void

168. Plaintiffs incorporate the foregoing paragraphs in support of the following causes of action.

169. Plaintiffs hereby petition the Court pursuant to the UDJA.

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[55] *See* American Academy of Pediatrics, Policy Statement, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 PEDIATRICS 4 (Oct. 2018) https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for.

[56] *See* Am. Med. Ass'n House of Delegates, Resolution 122: Removing Financial Barriers to at Care for Transgender Patients at 1 (2008), http://www.tgender.net/taw/ama_resolutions.pdf.

[57] *See* Endocrine Soc'y & Pediatric Endocrine Soc'y, Position Statement, *Transgender Health* Position Statement (2020), https://www.endocrine.org/-/media/endocrine/files/advocacy/position-statement/position_statement_transgender_health_pes.pdf.

[58] *Id.*; *see also* Pediatric Endocrine Society, Position Statement, T*he Pediatric Endocrine Society Opposes Bills That Harm Transgender Youth* (Apr. 2021), https://pedsendo.org/news-announcements/the-pediatric-endocrine-society-opposes-bills-that-harm-transgender-youth-2/.

[59] *See* Am. Psych. Ass'n, Position Statement, *Access to Care for Transgender and Gender Diverse Individuals* (2018), https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Discrimination-Against-Transgender-and-Gender-Diverse-Individuals.pdf.

[60] *See* Am. Acad. of Fam. Physicians, Resolution No. 1004 (2012), http://www.aafp.org/dam/AAFP/documents/about_us/special_constituencies/2012RCAR_Advocacy.pdf.

[61] *See* Am. Coll. of Obstetricians and Gynecologists, Committee Opinion No, 823: Health Care for Transgender Individuals (2021), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals.pdf.

[62] *See* Nat'l Ass'n of Soc. Workers, Press Release, *Gender Affirming Care Saves Lives* (Mar. 28, 2023), https://www.socialworkers.org/News/News-Releases/ID/2642/Gender-Affirming-Health-Care-Saves-Lives.

[63] *See* WPATH, Position Statement, *Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.* (Dec. 21, 2016), https://www.wpath.org/newsroom/medical-necessity-statement.

170. Section 37.002 of the UDJA provides that it is remedial, and its purpose is to settle and to afford relief from uncertainty and insecurity with respect to rights, status, and other legal relations; and it is to be liberally construed and administered. Tex. Civ. Prac. & Rem. Code § 37.002(b).

171. Under Section 37.003 of the UDJA, a court of proper jurisdiction has the power to declare rights, status, and other legal relations, whether or not further relief is or could be claimed. *Id.* § 37.003(a). The declaration may be either affirmative or negative in form and effect and the declaration has the force and effect of a final judgment or decree. *Id*. § 37.003(b).

172. As explained above, an actual controversy exists between Plaintiffs and Defendants concerning rights and obligations under Texas law, including the Texas Constitution.

173. Plaintiffs hereby seek a declaratory judgment that the Ban violates Article I, § 19; Article I, § 3; and Article I, § 3a of the Texas Constitution and is therefore void.

B. Due Course of Law – Parental Rights with Respect to Minor Children

174. Plaintiffs incorporate the foregoing paragraphs in support of the following causes of action.

175. The Ban prevents parents from making medical care decisions concerning their children in violation of Parent Plaintiffs' and PFLAG parent members' Due Course of Law rights to parental autonomy.

176. The Due Course of Law Clause of the Texas Constitution protects the fundamental right of parents to make decisions concerning the care, custody, and control of their children. Tex. Const. art. I, § 19.

177. That fundamental right of parental autonomy includes the right of parents to seek and follow medical advice to protect the health and wellbeing of their minor children.

178. Parents' fundamental right to seek and to follow medical advice is at its apex when the parents' and child's liberty interests in pursuing a course of medical care align, and the child's medical providers agree and have recommended as appropriate the course of medical treatment.

179. The Ban's prohibition on providing evidence-based and medically necessary treatment for adolescents with gender dysphoria stands directly at odds with parents' fundamental right to make decisions concerning the care of their children, particularly when it aligns with the adolescent's liberty interests and the recommendations of their medical providers. The Ban interferes with Texas families' private decisions and strips Texas parents, including Parent Plaintiffs and PFLAG parent members, of the right to seek, direct, and provide medical care that their children need.

180. The Ban does nothing to protect the health or wellbeing of minors. To the contrary, it gravely threatens the health and wellbeing of adolescents with gender dysphoria by denying their parents, including Parent Plaintiffs and PFLAG parent members, the ability to obtain necessary and often lifesaving medical treatment for their children.

181. The Ban's prohibition against the provision of medically accepted treatments for adolescents with gender dysphoria is not narrowly tailored to serve a compelling government interest. Here, the Ban lacks even a rational relationship to any legitimate government interest. Thus, the Ban violates Plaintiff Parents' and Plaintiff PFLAG parent members' fundamental rights under Article I, § 19 of the Texas Constitution.

182. Parent Plaintiffs and Plaintiff PFLAG parent members are entitled to a declaratory judgment that the Ban violates Article I, § 19 of the Texas Constitution.

C. Due Course of Law – Property Rights of Physicians in their Medical Licenses and Liberty Rights of Medical Providers to Engage in their Occupations

183. Plaintiffs incorporate the foregoing paragraphs in support of the following causes of action.

184. The Ban deprives Physician Plaintiffs and Plaintiff GLMA members of their vested property interests in their medical licenses and their rights to occupational liberty without due course of law.

185. Under the Texas Constitution, "[n]o citizen of this State shall be deprived of life, liberty, property, privileges or immunities, or in any manner disfranchised, except by the due course of the law of the land." Tex. Const. art. I, § 19.

186. Article I, Section 19 of the Texas Constitution safeguards Texas-licensed physicians against unwarranted, improper interference with their vested property interests in their medical licenses and protects all medical providers from such interference with their right to practice their profession by providing medically indicated treatment to transgender adolescents according to the generally accepted standard of care to alleviate the patient's gender dysphoria that the physician determines poses a risk to the transgender adolescent's health and wellbeing.

187. The Ban violates Physician Plaintiffs' and GLMA members' rights under Section 19 because it bans them from providing medically indicated treatment to transgender adolescents according to the generally accepted standard of care to alleviate the patient's gender dysphoria, puts physicians' medical licenses in jeopardy if they provide such treatment, and threatens other disciplinary action and penalties under the Texas Medical Practice Act.

188. The Ban does not serve a proper legislative purpose; there is no real and substantial connection between a legislative purpose and the language of SB14, and the Ban works an excessive burden on Texas medical providers treating transgender adolescent patients such that

relative to the purported purpose of SB14, the Ban is oppressive. Here, the Ban lacks even a rational relationship to any legitimate government interest.

189. Physician Plaintiffs and Plaintiff GLMA members seek a declaratory judgment that the Ban deprives Plaintiff physicians of vested property interests in their medical licenses and infringes on Plaintiff medical providers' right to occupational liberty under Article I, Section 19 of the Texas Constitution.

D. Texas Equal Rights Amendment – Plaintiffs' Equality Denied and Abridged Because of Sex

190. Plaintiffs incorporate the foregoing paragraphs in support of the following causes of action.

191. The Ban discriminates because of sex in violation of all Plaintiffs' rights to equality under the Equal Rights Amendment of the Texas Constitution.

192. Under the Texas Constitution, "[e]quality under the law shall not be denied or abridged because of sex, race, color, creed, or national origin." Tex. Const. art. I, § 3a. It protects individuals and groups from discrimination by the government.

193. The Ban classifies based on sex on its face. The Ban harms transgender adolescents, including Minor Plaintiffs, Plaintiff PFLAG minor members, and the patients whom Physician Plaintiffs and Plaintiff GLMA members treat, by denying them medically necessary treatment because of their sex assigned at birth.

194. The Ban also discriminates against Parent Plaintiffs and Plaintiff PFLAG parent members by denying them the same ability to secure necessary medical treatment for their children that other parents can obtain, and it does so because of their child's sex assigned at birth.

195. Under the Texas Equal Rights Amendment, government discrimination based on sex is presumptively unconstitutional and subject to strict scrutiny, placing a demanding burden upon the State to show the law is narrowly tailored to serve a compelling government interest.

196. Discrimination on the basis of nonconformity with sex stereotypes, transgender status, gender, gender identity, gender transition, and sex characteristics are all forms of discrimination because of sex.

197. By its very terms, the Ban facially discriminates because of sex. The Ban prohibits any "physician or health care provider" from "knowingly" "provid[ing], prescrib[ing], administer[ing], or dispens[ing]" certain "procedures and treatments" to a minor "[f]or the purpose of transitioning" a minor's "biological sex as determined by the sex organs, chromosomes, and endogenous profiles" or "affirming the [minor]'s perception" of their sex "if that perception is inconsistent with the [minor]'s biological sex." SB14 § 2 (proposed Tex. Health & Safety Code § 161.702).

198. Under the terms of the Ban, whether a person can receive certain medical treatment turns on their assigned sex at birth.

199. Under the terms of the Ban, whether a person can receive certain medical treatment turns on whether they are transgender.

200. Under the terms of the Ban, whether a person can receive certain medical treatment turns on whether the treatment tends to reinforce or disrupt stereotypes associated with the person's sex assigned at birth.

201. Discrimination in the exercise of a fundamental right is also presumptively unconstitutional and is subject to strict scrutiny. The Ban unconstitutionally discriminates against Parent Plaintiffs and Plaintiff PFLAG parent members in the exercise of their fundamental right

to make decisions concerning the care, custody, and control of their children by prohibiting them from seeking and following medical advice to protect the health and wellbeing of their children solely because of their child's sex assigned at birth.

202. The Ban does nothing to protect the health or wellbeing of minors. To the contrary, it gravely threatens the health and wellbeing of adolescents with gender dysphoria by denying them access to evidence-based, medically necessary, and often lifesaving medical treatment.

203. The Ban is not narrowly tailored to achieve a compelling governmental interest. Here, the Ban lacks even a rational relationship to any legitimate government interest.

204. The Ban's targeted prohibition on medically necessary treatment for transgender adolescents with gender dysphoria is based on generalized fears, negative attitudes, stereotypes, and moral disapproval of transgender people, which are not legitimate bases for unequal treatment under any level of scrutiny.

205. The Ban deprives transgender adolescents and their parents or guardians, including Family Plaintiffs, Plaintiff PFLAG members, and the patients of Physician Plaintiffs and Plaintiff GLMA members, of their right to equality under the law because of sex and stigmatizes them as second-class citizens in violation of the Texas Equal Rights Amendment. The Ban also inflicts upon transgender adolescents and their parents or guardians, including Family Plaintiffs, Plaintiff PFLAG members, and the patients of Physician Plaintiffs and Plaintiff GLMA members, distress, humiliation, embarrassment, emotional pain and anguish, violation of their dignity, and harms to their short- and long-term health and wellbeing from being denied access to medically necessary healthcare.

206. Plaintiffs seek a declaratory judgment that the Ban violates Article I, § 3a of the Texas Constitution.

E. Equal Rights for Transgender People

207. Plaintiffs incorporate the foregoing paragraphs in support of the following causes of action.

208. The Ban discriminates because of transgender status in violation of Plaintiffs' equal rights guaranteed to all persons under the law by Article I, § 3 of the Texas Constitution.

209. The Ban classifies based on transgender status on its face. The Ban harms transgender adolescents, including Minor Plaintiffs, Plaintiff PFLAG minor members, and the patients whom Physician Plaintiffs and Plaintiff GLMA members treat, by denying them medically necessary treatment because of their transgender status.

210. The Ban also discriminates against Parent Plaintiffs and Plaintiff PFLAG parents in the exercise of their fundamental right to make decisions concerning the care, custody and control of their children by denying them the same ability to secure necessary medical treatment for their children that other parents can obtain on the basis of their child's transgender status.

211. The equal rights provision of the Texas Constitution protects transgender people as a class from being singled out as a special subject for discriminating or hostile legislation, such as SB14. *See Burroughs v. Lyles*, 181 S.W.2d 570, 574 (Tex. 1944).

212. Government discrimination based on transgender status is presumptively unconstitutional and subject to at least heightened scrutiny.

213. By its very terms, the Ban facially discriminates against transgender adolescents. The Ban prohibits any "physician or health care provider" from "knowingly" "provid[ing], prescrib[ing], administer[ing], or dispens[ing]" certain "procedures and treatments" to a minor "[f]or the purpose of transitioning" a minor's "biological sex as determined by the sex organs, chromosomes, and endogenous profiles" or "affirming the [minor]'s perception" of their sex "if

that perception is inconsistent with the [minor]'s biological sex." SB14 § 2 (proposed Tex. Health & Safety Code § 161.702).

214. Under the terms of the Ban, whether a person can receive certain medical treatment turns on whether they are transgender.

215. Discrimination in the exercise of a fundamental right is also presumptively unconstitutional and is subject to strict scrutiny. The Ban unconstitutionally discriminates against Parent Plaintiffs and Plaintiff PFLAG parent members in the exercise of their fundamental right to make decisions concerning the care, custody, and control of their children by prohibiting them from seeking and following medical advice to protect the health and wellbeing of their children solely because their child is transgender.

216. The Ban does nothing to protect the health or wellbeing of minors. To the contrary, it gravely threatens the health and wellbeing of adolescents with gender dysphoria by denying them access to evidence-based, medically necessary, and often lifesaving medical treatment.

217. The Ban is not narrowly tailored to achieve a compelling governmental interest. It is not substantially related to any important government interest. And it is not rationally related to any legitimate government interest.

218. The Ban's targeted prohibition on medically necessary treatment for transgender adolescents with gender dysphoria is based on generalized fears, negative attitudes, stereotypes, and moral disapproval of transgender people, which are not legitimate bases for unequal treatment under any level of scrutiny.

219. The Ban deprives transgender adolescents and their parents or guardians, including Family Plaintiffs, Plaintiff PFLAG members and the patients of Physician Plaintiffs and Plaintiff GMLA members, of their right to equal rights and stigmatizes them as second-class citizens in

violation of Article I, § 3 of the Texas Constitution. The Ban also inflicts upon transgender adolescents and their parents, including Minor Plaintiffs, Parent Plaintiffs, Plaintiff PFLAG members, and the patients of Physician Plaintiffs and Plaintiff GLMA members, distress, humiliation, embarrassment, emotional pain and anguish, violation of their dignity, and harms to their short- and long-term health and wellbeing from being denied access to medically necessary healthcare.

220. Plaintiffs seek a declaratory judgment that the Ban violates Article I, § 3 of the Texas Constitution.

X. APPLICATION FOR TEMPORARY AND PERMANENT INJUNCTION

221. In addition to the above-requested relief, pursuant to Texas Civil Practice and Remedies Code Section 65.011 *et seq.* and Texas Rule of Civil Procedure 680 *et seq.*, to preserve the status quo pending a full trial on the merits, *see Butnaru v. Ford Motor Co*., 84 S.W.3d 198, 204 (Tex. 2002), Plaintiffs request a temporary injunction against all Defendants that enjoins Defendants from taking any action to enforce SB14 pending the full resolution of the merits.

222. Plaintiffs stated a valid cause of action against Defendants.

223. Plaintiffs have a probable right to relief because, for the reasons stated herein, SB14 is unconstitutional in violation of the Due Course of Law and Equality Clauses of the Texas Constitution.

224. As described above, Plaintiffs will suffer probable, imminent, and irreparable injuries unless this Court grants their request for injunctive relief.

225. The threatened injury to Plaintiffs substantially outweighs the harm, if any, that Defendants would suffer from having to forestall enforcement of the Ban, pending resolution of the action.

226. Plaintiffs have no adequate remedy at law.

227. Accordingly, in order to preserve the status quo, Plaintiffs request that Defendants be cited to appear, and, after a full hearing, further request that the Court enter a temporary injunction.

228. Plaintiffs are willing to post a bond for any temporary injunction, but request that the bond be minimal because Defendants are acting in a governmental capacity, have no pecuniary interest in the suit, and no monetary damages can be shown. Tex. R. Civ. P. 684.

229. Further, Plaintiffs request that this Court set this matter for trial and, upon final hearing, that this Court enter a permanent injunction against all Defendants on each of the grounds asserted by Plaintiffs herein.

XI. CONDITIONS PRECEDENT

230. All conditions precedent have been performed or have occurred.

XII. PRAYER FOR RELIEF

231. For the foregoing reasons, Plaintiffs request the Court grant the following relief:

A. Upon hearing, a temporary injunction enjoining and restraining Defendants, their officers, agents, servants, employees, attorneys, and those in active concert or participation with them from implementing or enforcing any provision of SB14;

B. After trial, a permanent injunction enjoining and restraining Defendants, their officers, agents, servants, employees, attorneys, and those in active concert or participation with them from implementing or enforcing any provision of SB14;

C. A judgment against Defendants declaring that SB14 is unconstitutional, void, and unenforceable in its entirety, as described herein, including:

1. A declaration that SB14 violates Article I, Section 19 of the Texas Constitution by infringing upon the rights of parents to parental autonomy;

2. A declaration that SB14 violates Article I, Section 19 of the Texas Constitution by depriving physicians of their vested property interests in their medical licenses and infringing upon medical providers' right to occupational liberty;
3. A declaration that SB14 violates Article I, Section 3a of the Texas Constitution by discriminating against transgender adolescents and their parents because of sex in violation of their right to equality under the law;
4. A declaration that SB14 violates Article I, Section 3 of the Texas Constitution by discriminating against transgender adolescents and their parents because of transgender status in violation of their right to equal rights guaranteed to all persons;

D. To retain jurisdiction after judgment for the purposes of issuing further appropriate injunctive relief if the Court's declaratory judgment is violated;

E. To award costs and reasonable and necessary attorney's fees as are equitable and just under Tex. Civ. Prac. & Rem. Code § 37.009; and

F. To grant all other and further relief, general or special, whether in law or equity, as the Court deems just and proper.

Signature page to follow.

Dated: July 12, 2023

Respectfully submitted:

By: *<u>/s/ Kennon L. Wooten</u>*

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**pro hac vice* motion forthcoming

Exhibit 1

CAUSE NO. _____

LAZARO LOE, *et al*.,	§	IN THE DISTRICT COURT OF
Plaintiffs,	§	
v.	§	TRAVIS COUNTY, TEXAS
THE STATE OF TEXAS, *et al*.,	§	
Defendants.	§	_____ JUDICIAL DISTRICT

DECLARATION OF LAZARO LOE

---

1. My name is Lazaro Loe. I am over 18 years of age, of sound mind, and capable of making this affidavit. The facts stated in this affidavit are within my personal knowledge and are true and correct. I would testify competently to these facts if called to do so.

2. I am a Plaintiff in this case and live in Bexar County, Texas. I am bringing claims on behalf of myself and as the parent and next friend of my daughter, Luna Loe.[1] Luna's mom and I are now divorced, but we are both supportive of Luna and love her dearly.

3. I am a member of PFLAG, which is also a Plaintiff in this case.

4. Luna and I are both Hispanic/Latino. My grandparents immigrated to the United States from Spain and Mexico.

5. My parents met in the Air Force and my father worked afterwards as a career civil servant for the U.S. government.

6. I was born in Texas and grew up active in the Catholic Church. Growing up, I

[1] Lawrence Loe and Luna Loe are both pseudonyms. My daughter (who is a minor) and I are both proceeding pseudonymously to protect our right to privacy and ourselves from discrimination, harassment, and violence, as well as retaliation for seeking to protect our rights.

would frequently hear classmates and adults speak disparagingly about Mexicans, Mexican Americans, and people of other ethnicities. These kinds of words were always difficult to hear. My father educated me, though, to treat everyone with equal respect and dignity. My mother taught that everyone is deserving of love.

7. I have lived in Texas for most of my life. I am in the residential construction and private contracting industry and have made upgrades and improvements to many different historic properties and older homes in my area. I also own several properties. I pay taxes in this state, and my life, business, and home are all in Texas.

8. Luna was born in Texas, and this is the only home she's ever known. As a father, my primary goal is to ensure that Luna is safe, taken care of, and has everything she needs to thrive. Because of recent political attacks against transgender Texans, and SB 14 in particular, my ability to be a great dad for my kid has become much more difficult.

9. Luna is twelve years old and is a transgender girl. She was assigned the sex male at birth but her gender identity is female.

10. Luna uses she/her pronouns and is entering seventh grade. I had early indications that my daughter is a girl from her very early days of growing up. Luna always expressed extreme discomfort wearing boys' clothes or uniforms; but when she was allowed to wear girls' clothes, her discomfort immediately disappeared.

11. Luna's favorite color has always been pink, and she loved wearing dresses growing up. By the time that Luna was five or six years old, her friends naturally started using female pronouns for her and she went by female nicknames. Although it took me a bit of time to fully accept that Luna is transgender, I supported her by purchasing girls' clothes that she started wearing to school in first grade. She preferred to have her hair long and has kept growing out her

hair since kindergarten.

12. As my daughter persisted in her female gender identity, I tried to educate myself as a parent about what she might be going through. I first read a book called the *Gender Creative Child,* which was very illuminating. I then found other ways to educate myself. I researched articles and watched documentary films about our transgender families and their experiences. I learned more about what it means for someone to be transgender, especially as a child.

13. As a parent, I have always wanted what is best for my daughter and wish that I had understood even sooner what she would go through as a transgender young person and what she was dealing with from an early age. I also worried—and still worry—that she would face bullying, harassment, and discrimination as she got older.

14. There isn't any one moment that my daughter socially transitioned, since many of her friends have consistently known her as a girl since kindergarten. But by Luna's fourth grade year, in late 2020, she started asking everyone she knew to only use she/her/hers pronouns and refer to her by her chosen female name.

15. Being able to fully be herself as a girl at school and in public provided tremendous relief to Luna, who became happier, more social, and more self-confident. Her school performance dramatically improved. My daughter thrived, even as her school year was interrupted by the COVID-19 pandemic. Although this was a tough year for many, through family support and the support of her school and peers, it was the best school year Luna experienced academically to date. She has continued to excel and thrive ever since. To put it simply, Luna was ecstatic to fully be who she is in all areas of her life.

16. Luna first went to see a child psychologist when she was six years old. She opened up to her therapist from their first appointment and they built a strong relationship full of mutual

trust. Her psychologist diagnosed Luna with gender dysphoria based on Luna's developmental history, behavioral observations, and mental status exam.

17. Since 2017, Luna continued seeing her child psychologist. As she received this mental health support, I started researching health care that my daughter would need as she grows older. I found a clinic that provides health care to transgender adolescents. Together with Luna's mom, we decided to bring Luna to see a pediatric endocrinologist for an evaluation. Because Luna had been diagnosed with gender dysphoria, the pediatric endocrinologist started monitoring Luna's bloodwork and hormone levels over the course of a year with four separate appointments.

18. Luna told us that she did not want to go through puberty as a boy and couldn't fathom that happening. When her pediatric endocrinologist told us that puberty blockers would be medically necessary for the treatment of her gender dysphoria, Luna, her mother, and myself all agreed that starting puberty blockers was in Luna's best interest. We spoke with the doctor about the possible side effects of puberty blockers and we collectively determined that it would be beneficial and necessary for Luna to start receiving this medication.

19. Luna was excited to begin puberty blockers because she understood that they would help her continue to be her true and authentic self. She has thrived since socially transitioning at school and she doesn't want to face the trauma and hardship of being forced to be someone that she is not.

20. Luna has now been on puberty blockers for a year and they have had a hugely positive effect on her life. I have seen these positive changes first-hand as her dad.

21. My daughter has been given a reprieve from being forced to go through the wrong puberty, something that would be catastrophic for her mental health. She has been given the space she needs to be herself.

22. Luna is a girl who loves wearing her various girls' clothing styles and enjoys being with her female friends. She wears a two-piece swimsuit when she goes swimming or to the beach. (Her unicorn bathing suit has brought her so much joy this summer!). Being forced to go through puberty as a boy would upend and ruin her life, and mine as well.

23. Luna's mom and I want what is best for her and have seen the positive changes of her social transition and from puberty blockers. Luna has told me countless times that "of course I'm a girl" and was horrified last year when Ken Paxton tried to reclassify the health care she needs as "child abuse" under Texas law. She feared that she would be taken away from us and could lose access to the health care that she needs. The threat of being investigated by the state traumatized our family.

24. Even as a middle schooler, Luna has followed what has happened at the Texas Legislature and political attacks facing transgender youth across the country. She wants to stand up for herself and others like her, and be allowed to be who she is here in Texas without the government trying to block the health care that she needs to thrive.

25. The hostile environment in our state has already threatened interruptions to Luna's medical care, since the clinic where she originally saw a pediatric endocrinologist has now closed down. I had to scramble to find another doctor for my child and Luna is still able to access care in Texas, but SB 14 threatens to cut this care off completely. We are presently trying to find Luna health care out of state if this law goes into effect, but seeking care so far away is expensive, burdensome, and logistically difficult. It is also deeply discriminatory and sends a hateful message to my daughter that she is unwelcome in Texas and can't access the health care that she needs in the state where she was born and has lived all of her life.

26. Despite the political attacks against transgender youth in our state, Luna is

thriving in her school and our community. Her teachers and friends love her and want her to succeed and be happy, like all other kids. Luna enjoys swimming and is involved in art, piano, and theater, and tennis. She loves veggie ramen and sleepovers with her friends. She keeps busy and she loves her school. She has a thriving social life, while simultaneously being scared of our state legislators and politicians who seem intent on harming her.

27. It would be incredibly difficult and inconvenient for me and Luna to have to move and start a new life somewhere else. Luna's school is here, my career and business are here, and our home is here. We love Texas and want to stay here, but we may be forced to leave if our state cuts off access to the health care that Luna's doctors have determined to be medically necessary, and that we have collectively decided is in Luna's best interest.

28. If this health care ban goes into effect, Luna's access to health care would be in jeopardy, and my ability as a parent to provide best-practice, evidence-based health care to my child would be destroyed. Being able to access puberty blockers has had a tremendously positive effect on Luna's health and wellbeing. Losing access to this care and being forced to go through puberty based on her sex assigned at birth would severely harm my child.

29. As she grows older, Luna's doctors have also indicated that she would likely benefit from hormone therapy as medically necessary to treat her gender dysphoria, and will likely need this treatment in the near future. This would also be blocked by SB 14 if the law goes into effect. Luna, her mom, and I want her to have access to hormones that are medically necessary. This discriminatory law will prevent us from doing so. It is important to us to ensure that Luna can secure the health care that she needs to stay happy and healthy.

30. Continuing to access puberty blockers and seeking hormones in the near future to mitigate the symptoms of gender dysphoria is vital to Luna's health and wellbeing. As a parent, I

don't want to see my child suffer and don't understand why the state government would try to strip away my ability to seek the best possible health care for my child.

31. If SB 14 goes into effect and Luna loses access to this health care, I am deeply concerned about the anxiety, depression, and suicidality that she will face. Her body would masculinize and change physically, which would cause her irreparable harm. The years of work she has spent with her psychologist and medical team would be lost. Her happiness, health, autonomy, and independence would be stripped away by this cruel legislation; and we likely would be forced to leave our home here in Texas.

32. I can't imagine being forced to move out of state. Texas is the only home that Luna has ever known and my business, property, and life are all here. We would likely have to move out of state if it was the only way to continue accessing Luna's medically necessary health care. This would devastate our family and harm our community as a whole.

33. I want to do everything in my power to help protect and support my daughter. She is such a strong advocate for who she is and other people like her. Her bravery and fearlessness have been an inspiration for myself and all of those who meet her. If you met her or talked to her for thirty seconds, you would know immediately that she is a girl and is happy and thriving as who she is. SB 14 threatens to upend and ruin her life, and stopping the law from going into effect would immediately help her and allow her to continue to receive the health care that her doctors have determined is medically necessary.

34. My name is [redacted], my date of birth is [redacted]. My address is [redacted]. I declare under penalty of perjury that the foregoing is true and correct.

Executed in Bexar County, State of Texas on Jul 9, 2023.

[redacted]

[redacted]

Lazaro Loe

Lazaro Loe (Jul 9, 2023 15:29 CDT)

Lazaro Loe

Exhibit 2

CAUSE NO. _____

LAZARO LOE, *et al*.,	§	IN THE DISTRICT COURT OF
Plaintiffs,	§	
v.	§	TRAVIS COUNTY, TEXAS
THE STATE OF TEXAS, *et al*.,	§	
Defendants.	§	_____ JUDICIAL DISTRICT

DECLARATION OF MARY MOE

---

1. My name is Mary Moe. I am over 18 years of age, of sound mind, and capable of making this affidavit. The facts stated in this affidavit are within my personal knowledge and are true and correct. I would testify competently to these facts if called to do so.

2. I am the mother of Maeve Moe, my nine-year-old daughter, and her brother. I have been married to my spouse and Maeve's father, Matthew Moe, for ten years.[1]

3. I am a member of PFLAG, which is also a plaintiff in this case.

4. My daughter Maeve is a sweet, intelligent child whom I love very much. She has always been curious and loved to learn; she began reading at a very early age. She loves geography, Girl Scouts, and dance, and she excels in school in the gifted and talented track. Her father and I are very proud of her.

5. Maeve is transgender. When she was born, she was assigned male, but she has vocally expressed from a very early age that she is a girl.

[1] Mary Moe, Maeve Moe, and Matthew Moe are all pseudonyms. My daughter (who is a minor), her father, and I are proceeding pseudonymously to protect our right to privacy and ourselves from discrimination, harassment, and violence, as well as retaliation for seeking to protect our rights.

6. As soon as she could talk, Maeve expressed wanting girl things throughout toddlerhood into school age. One night she even asked me, “Will I ever like boy things?” When my mother bought Maeve a princess dress as a present, Maeve loved it and just beamed from ear to ear.

7. At first, we only let Maeve wear girls’ clothes at home, but we saw how anxious Maeve got when she had to put on boys’ clothes to leave the house. When she would be out in boys’ clothes, she would bite her nails, avoid eye contact, and her usual curiosity dampened. One day, when Maeve was about four years old and I was getting her dressed for preschool, Maeve broke down in tears saying she didn’t like her clothing. I cancelled her preschool that day and took her clothes shopping, telling her to get clothing that felt comfortable. Maeve picked out girl clothes and was overjoyed. I saw my child light up outside our home.

8. We had Maeve evaluated by a licensed professional counselor when she was five years old. The counselor recommended we affirm her gender identity to support her mental health and well-being. That was consistent with what we had experienced as a family; Maeve felt happiest when we allowed her to express herself as a girl. We want what is best for our daughter and so followed the counselor’s advice. We let Maeve wear the clothing she felt most comfortable in and used “she” pronouns for her.

9. In April 2019, Maeve’s primary care provider, a nurse practitioner, agreed with her counselor and wrote a letter of support for Maeve’s name change. The provider based this assessment on her observations of Maeve over the five years Maeve had been in her care, a review of scientific literature on transgender children, and consultation with Texas Children’s Hospital endocrinology unit.

10. Maeve legally changed her name when she was five and entered her kindergarten class as a girl. Most people do not know she is transgender.

11. When Maeve was about six, I took her to an endocrinologist. The endocrinologist taught Maeve how to monitor her body for signs of puberty so we would know when she would need to get puberty blockers. We visit this doctor every year to continue to evaluate Maeve. This endocrinologist has diagnosed Maeve with gender dysphoria.

12. Throughout elementary school, Maeve has lived openly as a girl and thrived. We spoke with her teachers, principal, and school administrators before she started school to tell them that Maeve is transgender, and it has not been a problem.

13. When my daughter begins puberty, she will need puberty blockers to prevent her body from changing in ways that do not align with her gender. Our doctor has said that it may be only a matter of months until Maeve will need them.

14. I have already discussed the potential side effects of puberty blockers with Maeve's doctors, with my husband, and with her. As parents, we have weighed the potential risks and benefits of this treatment, like we do for any of the medical conditions any of our children might have.

15. Maeve has lived openly as a girl since she was four years old, and being affirmed in her gender has helped her become the wonderful, intelligent young girl she is today. I am afraid of what would happen to her if Maeve was prohibited from receiving the health care she needs to live comfortably and safely in her body.

16. Maeve has always been concerned about her body changing in ways that do not match the girl she knows herself to be. The idea of that happening to her is extremely upsetting to Maeve.

17. When we first heard of the bill that became this law, we knew that it would affect Maeve's access to getting the care she needed in Texas and we might have to make drastic changes to make sure she had access to health care.

18. Because my daughter might need puberty blockers in the next few months, I am temporarily relocating out of state with her and my other child. Her father will stay behind to continue working in Texas. We all intend to return and reunite in our home once it is safe for Maeve to receive this care in the state.

19. I am heartbroken to have to take my children away from their home and their father, even temporarily. But I know that Texas is not a safe place for my daughter if this law forbids her access to this care.

20. My husband will continue to live in our house in Texas and I will keep my residency and professional license in Texas. Texas is our home. My husband and I want to continue to live and raise our children in the communities they have spent their whole lives in. We hope that once this law is struck down our family can be reunited in our home again.

21. My name is [redacted]. My date of birth is [redacted]. My address is [redacted]. I declare under penalty of perjury that the foregoing is true and correct.

Executed in Montgomery County, State of Texas on Jul 9, 2023.

[redacted]

[redacted]

Mary Moe (Jul 9, 2023 21:27 CDT)

Mary Moe

Exhibit 3

CAUSE NO. _____

LAZARO LOE, *et al*.,	§	IN THE DISTRICT COURT OF
Plaintiffs,	§	
v.	§	TRAVIS COUNTY, TEXAS
THE STATE OF TEXAS, *et al*.,	§	
Defendants.	§	_____ JUDICIAL DISTRICT

DECLARATION OF MATTHEW MOE

---

1. My name is Matthew Moe. I am over 18 years of age, of sound mind, and capable of making this affidavit. The facts stated in this affidavit are within my personal knowledge and are true and correct. I would testify competently to these facts if called to do so.

2. I am the father of Maeve Moe, my nine-year-old daughter, and her brother. I have been married to their mother, my wife Mary Moe, for ten years.[1] We live in Montgomery County.

3. I am a member of PFLAG, another plaintiff in this case.

4. I am a fourth-generation Texan and have lived in Texas all my life. Both of my children were born in Texas and have lived here all their lives too.

5. I love my daughter Maeve very much. She is smart, excelling in school, funny, and kind. I am proud to be her father.

[1] Mary Moe, Maeve Moe, and Matthew Moe are all pseudonyms. My daughter (who is a minor), her mother, and I are proceeding pseudonymously to protect our right to privacy and ourselves from discrimination, harassment, and violence, as well as retaliation for seeking to protect our rights.

6. Maeve is transgender and has expressed her gender almost since she could speak. When she was born, she was assigned male, but she has vocally expressed from a very early age that she is a girl. She always wanted to wear girls' clothes as a small child. At first, her mother and I would only let her wear them in the house. During that time, Maeve cherished Halloween because it was the one night of the year she could wear whatever she wanted outside of the house.

7. When she was about five-years-old, Maeve saw a licensed professional counselor, who recommended that we support Maeve in being who she is. We realized we needed to support our child fully and let her wear clothing that fit with her gender all the time. We also started using "she" pronouns for Maeve and helped her pick a name that suited her better.

8. Her mother and I had Maeve's name legally changed and we fully support her in being herself in school, where everyone knows her as a girl. She has done well in her school environment as a girl. She is making friends and excelling academically.

9. Mary and I have had to educate ourselves about how to support Maeve. We did not know a lot about transgender issues, but we wanted to fully support our daughter. Having Maeve as our child opened our hearts and our minds. We did our research and spoke with an endocrinologist about how we could keep our child healthy and happy as she grew up.

10. Maeve will soon need puberty blockers to keep her body from masculinizing through puberty. The endocrinologist we consulted with told us that this will likely happen in a matter of months.

11. My wife and I have discussed the risks and benefits of puberty blockers, taking into account what Maeve's doctors have explained and recommend and what Maeve herself has

told us. Just like we always do for both our children and any medical issues they have, we are trying to make the best decisions we can to keep her safe and healthy.

12. I'm worried about what would happen if Maeve is not able to safely live as herself. Last summer I took the kids on a road trip and we stopped at a gas station to use the bathroom. I didn't think it was safe for Maeve to go into the women's room alone, so I took her and my son into the men's room instead. Maeve said she didn't feel comfortable using the men's room and went to the women's room. She was upset that it suddenly wasn't safe for her to use the restroom she always has, and the idea of having to use the men's room for her safety and even entering that men's room briefly shook her up. It took a few days after that for her to recover and be back to herself.

13. I never want my child to have to suffer because she is unable to safely be herself. Because we are afraid of Maeve not being able to access the medical care she needs to do so, my wife will be taking Maeve and her sibling to live with relatives out of state. They intend to return once we know it is safe for Maeve to get the medical care she needs in Texas. It saddens me that these are the drastic measures we have to take to ensure our child's health and happiness.

14. I will be separated from my wife and children during these months, as I am staying in Texas to care for our home and continue my job. I will miss my family during this time but know that it is the best choice to keep Maeve safe, even if I cannot be with her. I hope that this law is ruled against so that my family will be able to safely come home again.

15. My name is [redacted]. My date of birth is [redacted]. My address is [redacted]. I declare under penalty of perjury that the foregoing is true and correct.

Executed in Montgomery County, State of Texas on Jul 9, 2023.

[redacted]

[redacted]

Matthew Moe (Jul 9, 2023 15:28 CDT)

Matthew Moe

Exhibit 4

CAUSE NO. _____

LAZARO LOE, *et al*.,	§	IN THE DISTRICT COURT OF
	§	
Plaintiffs,	§	
	§	
v.	§	TRAVIS COUNTY, TEXAS
	§	
THE STATE OF TEXAS, *et al*.,	§	
	§	
Defendants.	§	_____ JUDICIAL DISTRICT

DECLARATION OF NORA NOE

---

1. My name is Nora Noe. I am over 18 years of age, of sound mind, and capable of making this affidavit. The facts stated in this affidavit are within my personal knowledge and are true and correct. I would testify competently to these facts if called to do so.

2. I am a Plaintiff in this case. I am bringing claims on behalf of myself and as the parent and next friend of my son, Nathan Noe,[1] who is also a Plaintiff in this Action.

3. I have lived in Texas since 2009. My husband and I have three children. We currently live in Williamson County. We are members of PFLAG.

4. Our oldest child, Nathan, is a transgender boy. He was assigned female at birth but he is a boy.

5. Nathan was a healthy baby and a very happy, outgoing, gifted child. He excelled in school, had healthy social friendships, was part of a competitive swim team and was a leader

[1] Nora Noe and Nathan Noe are both pseudonyms. My son (who is a minor) and I are both proceeding pseudonymously to protect our right to privacy and ourselves from discrimination, harassment, and violence, as well as retaliation for seeking to protect our rights.

in his martial arts school. He was an active volunteer, and has been recognized in our community for raising funds to assist those affected by Hurricane Harvey.

6. Around age ten and eleven, we noticed a dramatic change in Nathan's personality. He became withdrawn, he stopped participating at school, and his grades fell. He started adopting compulsive and repetitive behaviors, like holding his breath, and requiring elaborate and strict routines around daily tasks. My husband and I had no idea what was wrong, but we knew we needed to get him help. We talked to our family doctor and found a mental health provider to do a full psychological evaluation. That provider ruled out a number of potential conditions, including autism, and we were told that Nathan had anxiety and possibly obsessive-compulsive disorder. We continued with therapy and stress management, while learning about triggers that caused the most distressing symptoms. While Nathan still tended to withdraw and stay private, my husband and I made sure to nurture open lines of communication.

7. When school moved online because of the COVID-19 pandemic, Nathan just could not participate. I later learned that this was because the sound of his own voice was so distressing to him, and because he did not want to see his own face on the computer screen. It got so bad that we had to pull him out of school and do homeschooling for the remainder of his eighth-grade year.

8. The worst of this came when Nathan was thirteen, which was when he began menstruation. We could barely get him to leave his room. He would curl up on the sofa and it seemed any participation was unbearable. He couldn't seem to put any words together to explain what he was experiencing, and just looked haunted and empty. It was horrible. We visited our doctor who ruled out any underlying physical or hormonal illness.

9. A few months after his thirteenth birthday, around March of 2020, Nathan came out as transgender. We had planned to go swimming one day, and I knew something was wrong when he told me he'd changed his mind and didn't want to go. I asked him what was wrong, and he said, "I think I might not be a girl."

10. Internally, I was shocked - this was not something I expected, and I thought Nathan was struggling with the wish that he wouldn't have to deal with menstruation. I had no experience with a female-to-male transition, and had no understanding of what this meant for Nathan. Outwardly, I primarily listened. I reassured Nathan that we loved him no matter what, and that we would figure this out together as a family. I also told him that being trans comes with some extra challenges, and that we would need to get support to help us understand that. I knew we needed to find a therapist who could help. As we talked, it was evident that this had nothing to do with sexuality or attraction to any other gender - this was about Nathan's body and self.

11. Nathan asked if I would help him tell the rest of the family. He had already talked to his younger sister, and both of his siblings were immediately supportive and they continue to be fiercely protective of their big brother. When I talked to my husband, Nathan's dad, he was initially skeptical, and wanted to make sure we were taking the healthiest path for our child. He is wary of unnecessary medical intervention, and wanted to make sure that he learned as much as possible about what we considered for Nathan's care.

12. We took Nathan to see our family doctor, who did an evaluation and diagnosed Nathan with gender dysphoria, and Nathan started seeing a therapist who we found on a resource list of local providers with expertise in adolescent gender dysphoria. Because getting his period was so profoundly distressing, I also took Nathan to see my OBGYN, who prescribed birth control pills meant to stop him from getting his period. This was the first active medical

intervention we took for Nathan's transition. However, the pills did not control his menstrual symptoms effectively. The OBGYN recommended that we seek out the care of a specialist in adolescent medicine who could guide us with Nathan's care.

13. We began using his chosen name only a few weeks after he first came out to me. It was hard at first to remember, but I got some good advice about what to do if I used the wrong name or pronouns to remind myself. Because it was early in the pandemic, only a few people were aware of this social transition - our family, my mother who lives close by, and a few close friends. When Nathan did return to school, I requested that the school use his chosen name and the pronouns he/him, and they were very supportive of this. We have since then updated his legal documents to reflect this name and gender marker change.

14. In March 2021, Nathan started seeing a new physician who had expertise in treating kids with gender dysphoria. That doctor did an evaluation and walked us through the risks and potential benefits of Nathan starting testosterone. At home, Nathan, his father, and I discussed all of the potential side effects of testosterone, and also the potential impact on fertility, including that there might be some unknown risks. As Nathan's father and I have always done for our children when they have medical issues, we weighed the risks and benefits of this medical treatment, including the risk of doing nothing. Given Nathan's distress and the severity of his gender dysphoria, doing nothing was not an option for us.

15. Nathan started taking testosterone in November 2021, shortly before his 15th birthday. Since starting taking testosterone, Nathan has finally gone through a true male puberty. He stopped menstruating and his voice deepened. Before he started testosterone, he had been wearing large hoodies everyday (even in the summer) to hide in. After he began his hormone therapy, he began taking pride in his appearance. He started wearing clothes that fit him and

were appropriate for the hot weather in Texas. He returned to the activities that he loves - joining the high school choir, swimming and being social. As his voice deepened, he started taking leadership roles again, joining school clubs and even traveling to an out-of-state convention for journalism. Before he started testosterone, only his family and friends knew and affirmed that he was a boy. Now, anyone he meets immediately understands that he is a boy. He is so much more confident and comfortable. He is back to being an outstanding student, and we are so proud of him.

16. Nathan says his sophomore year of high school was the best year of his life so far, because he finally got to start the school year feeling like himself, and being comfortable in his own skin.

17. When he heard news of SB 14 passing, though, Nathan started having trouble focusing in school again, and I noticed that some of his prior anxiety symptoms seemed to be returning as well. My younger kids have been afraid about what all of this means for our family.

18. Nathan has already lost his local doctor for his gender affirming healthcare. In May 2023 we received a notice that our future appointments were canceled because the doctor's office was no longer providing gender affirming healthcare for minors in anticipation of the new law. Nathan also wants to get top surgery, which we have been discussing as a family, and which Nathan's doctor recommended as further treatment for his gender dysphoria. We had a consultation scheduled with a surgeon, but it was canceled after SB 14 passed. Having top surgery is, for Nathan, something he needs to fully alleviate his gender dysphoria, so he can look like the teenage boy he knows himself to be.

19. For now, we will take him to new doctors three hours away to continue monitoring Nathan's hormone replacement therapy. If SB 14 is allowed to take effect, we will be

forced to travel out of state to continue his care. This will be challenging for us. In addition to my two younger children, I am also the primary caregiver for my elderly mother, who lives next door to us. Traveling will also impact my ability to work at my job and will disrupt Nathan's school schedule—not to mention the added expense.

20. We love our community here in Texas. We can't and don't want to leave the state. I have been looking forward to having Nathan close to home when he goes off to college, but he is now considering going somewhere out of state because our government is making him feel unwelcome in his home.

21. If Nathan were forced to stop taking testosterone, I would be seriously worried for his wellbeing. I worry that he will not have access to the healthcare that he needs, that his schoolwork and his relationships would suffer once again, and that his future would be in jeopardy. I cannot allow that to happen to my child.

22. My name is [redacted]. My date of birth is [redacted]. My address is [redacted]. I declare under penalty of perjury that the foregoing (attached) is true and correct.

Executed in Williamson County, State of Texas on Jul 10, 2023.

[redacted]

Nora Noe

Nora Noe (Jul 10, 2023 10:49 CDT)

Nora Noe

Exhibit 5

CAUSE NO. _____

LAZARO LOE, *et al*.,	§	IN THE DISTRICT COURT OF
Plaintiffs,	§	
v.	§	TRAVIS COUNTY, TEXAS
THE STATE OF TEXAS, *et al*.,	§	
Defendants.	§	_____ JUDICIAL DISTRICT

DECLARATION OF SARAH SOE

---

1. My name is Sarah Soe. I am over 18 years of age, of sound mind, and capable of making this affidavit. The facts stated in this affidavit are within my personal knowledge and are true and correct. I would testify competently to these facts if called to do so.

2. I am a Plaintiff in this case. I am bringing claims on behalf of myself as the parent and next friend of my daughter, Samantha Soe, a fifteen-year-old girl about to start tenth grade.[1]

3. I am a member of PFLAG, which is also a Plaintiff in this case.

4. I am a Texas resident. I live in Hays County, Texas with my husband Steven Soe, our daughter Samantha, and Samantha's sibling. I work as an educator.

5. Samantha is resilient and confident. She loves choir, theater, geography, music, and video games.

6. My husband and I love Samantha and want her to be able to be herself.

[1] Sarah Soe, Steven Soe, and Samantha Soe are all pseudonyms. My daughter (who is a minor), husband, and I are all proceeding pseudonymously to protect our right to privacy and ourselves from discrimination, harassment, and violence, as well as retaliation for seeking to protect our rights.

7. Samantha is transgender. When she was born, her sex on her birth certificate was designated as male, but she is a girl.

8. When Samantha was around 12 years old, there were many nights where I would find her crying in bed and I would comfort her and encourage her to talk about her feelings. One night, she finally confided in me that she was transgender. She explained that she had reached this realization gradually and that she did not feel like a boy. I told her that she had plenty of time to figure out her feelings and her father reassured her that there are many ways to be a man, but my daughter insisted she was not a man.

9. When my daughter came out, my main concern was about protecting her. At first, it was hard for me to accept her changing her name because the name I gave her when she was born was a family name. However, I could see changing her name made her very happy. I don't know what the future holds but listening to my child's fears and concerns is where I begin. As a parent, I know my job is to parent her and help her.

10. Looking back, my daughter never fit stereotypical male gender norms. She was always snuggly, sweet, and a little shy and as she grew up, she became more talkative and sociable. She was never very interested in monsters or trucks like her male friends. She grew up wearing her sister's hand-me-downs. I never dressed her in exclusively "boy" colors like blue, but as she grew up and especially as she neared puberty, she became noticeably more uncomfortable being treated as a boy.

11. When my daughter first came out to her male friends, they rejected her, and she lost the ability to make new friends through sports teams due to the sports ban in Texas. School being remote during the COVID-19 pandemic made it difficult for her to make new friends, but

since she has returned to in-person learning, she has found some new friends who accept her as she is.

12. After Samantha came out to us, my husband and I started researching how best to support her mental health and we found her a counselor through a group for LGBTQ+ youth. Before starting gender-affirming care, Samantha struggled with depression, but since starting hormone therapy, her mental health has improved dramatically.

13. After my daughter came out, I asked her if she was comfortable discussing her gender identity with her pediatrician at her annual checkup. Samantha gave me the okay and at her 2020 checkup, she informed the pediatrician about her gender dysphoria. A year later, her pediatrician asked her if she still experiencing gender dysphoria, and Samantha affirmed that she did. It was at that visit that I asked Samantha's doctor for a referral to a doctor who could help treat our daughter's dysphoria, and her doctor referred us to Dell Children's.

14. After five months we were able to get an appointment at Dell Children's for Samantha and we first met with our pediatric endocrinologist in October 2021. This first appointment was only a consultation where our endocrinologist apprised us of the potential risks that come with taking puberty blockers and hormones including possible weight gain, mood swings, possible bone density loss, and potential infertility. It was also at this appointment that Samantha was officially diagnosed with gender dysphoria. After carefully weighing the risks, we decided that the benefits to Samantha of receiving gender-affirming care outweighed potential negative outcomes. Samantha received her first Lupron shot two weeks later and in December 2022, Samantha started hormone therapy and began taking estradiol. Samantha has been taking hormone therapy continuously since that time. We have taken measures to help encourage

Samantha to exercise and eat healthy food, take a vitamin D supplement to counter potential bone density loss, and see a counselor regularly to talk about mood.

15. Before meeting with Samantha's endocrinologist, we conducted our own research and read everything we could about gender dysphoria. We read peer-reviewed medical studies, books and news stories, and we spoke with multiple doctors. By the time of Samantha's first appointment, we had already spent years looking into how best to care for Samantha as a young trans girl.

16. We discussed the risks that our pediatric endocrinologist clarified for us as a family and concluded that the risks of delaying treatment were much more immediate, certain, and severe for Samantha than the potential risks posed by beginning gender-affirming care.

17. Since starting hormone therapy, Samantha's mental health has improved significantly. She now speaks much more positively about herself and her body and is excited about the feminine changes she is seeing in herself.

18. We fear Samantha will not be safe here in Texas. Samantha is considering not attending college here in Texas, even though she has always wanted to attend college in Texas and even though in-state tuition would be far less costly.

19. The prospect of having to stop Samantha's treatment is terrifying and upsetting. As parents, we want to protect Samantha from the bad in the world, but SB 14 has made that incredibly difficult. I fear losing access to the care that made her happy and confident will cause her to shut down emotionally. We are also considering having Samantha receive treatment out of state, but this would either require us to split up the family, send her to boarding school, or spend thousands of dollars on out-of-pocket care and travel. We have been able to obtain health care coverage for our daughter through our state employee plan and will lose coverage as a result of

SB 14. To afford moving, boarding school, or out-of-pocket care, my husband and I would likely have to delay our retirement by five years, and the emotional toll of splitting up our family cannot be valued.

20. We are a loving and caring family. The most important thing in the world to me is my child's safety, including her physical and mental health. My husband and I are educators and we raised our children to be kind and intelligent people. We never thought our daughter's medical care would be targeted by politicians or that we would join a lawsuit to fight such an attack. However, we have tried to do everything right and to be the best parents we can be for our kids and we have to do everything we can to protect them.

21. My name is [redacted]. My date of birth is [redacted]. My address is [redacted]. I declare under penalty of perjury that the foregoing is true and correct.

Executed in Hays County, State of Texas, on Jul 10, 2023.

[redacted]

[redacted]

Sarah Soe

Sarag=h soe (Jul 10, 2023 10:21 CDT)

Sarah Soe

Exhibit 6

CAUSE NO. _____

LAZARO LOE, *et al*.,	§	IN THE DISTRICT COURT OF
Plaintiffs,	§	
v.	§	TRAVIS COUNTY, TEXAS
THE STATE OF TEXAS, *et al*.,	§	
Defendants.	§	_____ JUDICIAL DISTRICT

DECLARATION OF STEVEN SOE

---

1. My name is Steven Soe. I am over 18 years of age, of sound mind, and capable of making this affidavit. The facts stated in this affidavit are within my personal knowledge and are true and correct. I would testify competently to these facts if called to do so.

2. I am a Plaintiff in this case. I am bringing claims on behalf of myself and as the parent and next friend of my daughter, Samantha Soe, a fifteen-year-old girl about to start tenth grade.[1]

3. I am a member of PFLAG, which is also a Plaintiff in this case.

4. I am a Texas resident. I live in Hays County with my wife, Sarah Soe, our daughter Samantha who is 15 years old, and Samantha's sibling. I work as an educator.

5. Samantha is resilient and confident. She loves choir, theater, geography, music and video games.

6. My wife and I love Samantha and want her to be able to be herself.

[1] Steven Soe, Sarah Soe, and Samantha Soe are all pseudonyms. My daughter (who is a minor), wife, and I are all proceeding pseudonymously to protect our right to privacy and ourselves from discrimination, harassment, and violence, as well as retaliation for seeking to protect our rights.

7. Samantha is transgender. When she was born, her sex was designated as "male" even though she is a girl.

8. When my daughter was around 12 years old, she began to cry at night when she went to bed. One night, she finally broke down and confessed to my wife that she is transgender. I spoke with my daughter and tried to reassure her that there are many ways to be a man, and that one doesn't have to be into "manly" things to be a man, but my daughter was very clear with me that she was not a man. We never knew or predicted we would have a transgender child.

9. When my daughter came out, my main concern was about protecting her. I worried that she would face hardships growing up as a transgender girl in Texas. But I knew that this was not about me and that I wanted to help to the best of my ability.

10. Looking back, my daughter never fit stereotypical male gender norms. She was always snuggly, sweet, and shy; and as she grew up, she became more talkative and sociable. She was never very interested in monsters or trucks like her male friends. She grew up wearing some of her sister's hand-me-downs and we never dressed her in exclusively "boy" colors like blue. As she grew up, especially as she neared puberty, she became noticeably more uncomfortable with her body and being treated as a boy.

11. When my daughter first came out to her male friends, they rejected her, and she lost the ability to make girlfriends through soccer due to the sports ban in Texas. School being remote during the COVID-19 pandemic also made it difficult for her to make new friends, but since she has returned to in-person learning, she has found some new friends who accept her as she is. I try to help her make friends through extracurricular activities.

12. After Samantha came out to us, my wife and I started researching how best to

support her mental health. Her mental health is very tied to her physical presentation as a girl, so part of that support included pursuing gender-affirming care. We found her a counselor through a group for LGBTQ+ youth. Samantha now sees a mental health counselor every 1-2 weeks.

13. After my daughter came out, my wife asked Samantha if she was okay discussing her gender identity with her pediatrician at her annual checkup. Samantha gave my wife the okay and at her 2020 checkup, Samantha informed her pediatrician what she was experiencing. A year later, her pediatrician asked her if she was still experiencing gender dysphoria, and when Samantha affirmed that she did and my wife asked her to refer us to a doctor to treat Samantha's gender dysphoria, Samantha's doctor referred us to Dell Children's.

13. After five months we were able to get an appointment at Dell Children's for Samantha with her endocrinologist in October 2021. This first appointment was only a consultation where her endocrinologist apprised us of the potential risks that come with taking puberty blockers and hormones. Samantha received her first Lupron shot two weeks later and in December 2022, Samantha started hormone therapy and began taking estradiol. Samantha has been taking hormone therapy continuously since that time.

14. Before meeting with Samantha's endocrinologist, we conducted our own research and read everything we could about gender dysphoria. We read peer-reviewed medical studies, books and news stories, and we spoke with multiple doctors. By the time of Samantha's first appointment, we had already spent years looking into how best to care for Samantha as a young trans girl.

15. We discussed the risks that our doctor disclosed to us as a family and concluded that the risks of delaying treatment were much more immediate, certain and severe for Samantha than the potential unwanted side-effects posed by beginning gender-affirming care.

16. Since starting hormone therapy, Samantha's mental health has improved significantly. She now speaks much more positively about herself and her body and she is excited to see the feminine changes in herself brought on by gender-affirming care. The prospect of having to stop Samantha's care is shattering. I am terrified that losing access to care would cause her to shut down emotionally and isolate.

17. We fear Samantha will not be safe here in Texas, especially given the anxiety and depression she has felt about potentially losing access to care. Samantha no longer wants to attend college here in Texas, even though in-state tuition would be far less costly.

18. To ensure Samantha receives proper care, my wife and I will need to split the family up, costing us thousands of dollars on out-of-pocket care and travel. To afford this, my wife and I will likely have to delay our retirement a number of years, and there will be an emotional toll on our family that cannot be valued. That said, my wife and I will find a way to make sure that Samantha is able to obtain the care that she needs, whatever the cost.

19. We have been able to rely upon our state employee health care coverage to help pay for our daughter's treatment for gender dysphoria and will lose converge as a result of SB 14.

20. We are a loving and caring family. The most important thing in the world to us is to safeguard our children's physical and mental well-being. My wife and I are teachers and we raised our children to be kind and intelligent people. We never thought our daughter's medical care would be targeted by politicians or that we would join a lawsuit to protect her care. However, we have to be the best parents we can be for our kids and we have to do everything we can to protect them.

21. My name is [redacted]. My date of birth is [redacted]. My address is [redacted]. I declare under penalty of perjury that the foregoing is true and correct.

Executed in Hays County, State of Texas on Jul 10, 2023.

[redacted]

[redacted]

Steven Soe (Jul 10, 2023 12:03 CDT)

Steven Soe

Exhibit 7

CAUSE NO. _____

LAZARO LOE, *et al*.,	§	IN THE DISTRICT COURT OF
Plaintiffs,	§	
v.	§	TRAVIS COUNTY, TEXAS
THE STATE OF TEXAS, *et al*.,	§	
Defendants.	§	_____ JUDICIAL DISTRICT

DECLARATION OF GINA GOE

---

1. My name is Gina Goe. I am over 18 years of age, of sound mind, and capable of making this affidavit. The facts stated in this affidavit are within my personal knowledge and are true and correct. I would testify competently to these facts if called to do so.

2. I am a Plaintiff in this case. I am bringing claims on behalf of myself and as the parent and next friend of my son, Grayson Goe,[1] who is also a Plaintiff in this Action. We are residents of McLennan County, Texas.

3. I am a member of PFLAG, which is also a Plaintiff in this case.

4. I work in the healthcare industry for a company in Texas.

5. My son Grayson is 15 years old.

6. Grayson is creative, has a talent for music, and is intelligent. He plays the guitar and the ukulele, and we love to have philosophical discussions together.

7. Grayson is a boy.

[1] Gina Goe and Grayson Goe are both pseudonyms. My son (who is a minor) and I are both proceeding pseudonymously to protect our right to privacy and ourselves from discrimination, harassment, and violence, as well as retaliation for seeking to protect our rights.

8. Grayson is transgender. He has a male gender identity but was assigned female when he was born.

9. Grayson told me who he was right before he turned 12 years old. He told me that he had known for a while and had been wanting to tell me.

10. I had watched Grayson struggle for many years with his mental health prior to telling me that he was transgender and that he was a boy. Since he was about nine years old, Grayson has been under the care of a psychologist. I started taking him to a psychologist because he always seemed to be extremely depressed and anxious. Back then, Grayson would spend most of his time in his room, isolated, and only really came out to eat.

11. Grayson's depression and anxiety were so bad that he started engaging in self-harm, which required emergency medical care on at least one occasion. Like any parent who knows their child is hurting, watching him go through that much pain was incredibly difficult for me, and I desperately wanted to help him get better.

12. After Grayson told me that he was transgender, I began to worry about how he would access the health care that he might need. As I work in the healthcare industry, I already had some knowledge about how difficult it can be for transgender people. I was also worried because we live in Texas and there had been previous legislation targeting transgender adolescents. I worried if Grayson and our family would be safe in Texas. I can say for certain though, that despite my worries, it never crossed my mind that I would not support my son in being who he is and getting him the health care that he needs. I love him, unconditionally, and I just want my child to be happy and healthy.

13. I first took Grayson to an adolescent medicine doctor in September 2020. He had previously been under the care of a nurse practitioner as his primary care provider, but I worried

that she would not be receptive to learning that he was transgender. I wanted to do my best to shield Grayson from any negative reactions to his identity.

14. It took Grayson a few visits with his new provider before he felt comfortable enough to tell him that he was transgender and that he needed gender-affirming care. But I was right there by his side at every appointment, supporting him. His new provider was really great about it after Grayson did tell him. Grayson was evaluated for and diagnosed with gender dysphoria.

15. Initially, Grayson was prescribed birth control to stop him from getting a period. At 12, the doctor determined that Grayson had already entered puberty and as such puberty blockers would not be appropriate treatment, but the birth control helped relieve some of his gender dysphoria, as did wearing a binder to make his chest appear flat and dressing in a more masculine way.

16. When Grayson turned 15, I found a provider who could evaluate Grayson for hormone therapy. Although birth control and wearing a binder helped Grayson feel more like himself, he still had gender dysphoria that prevented him from living his life fully. At that point, he had been living and presenting as a boy for over two years.

17. The provider conducted a very thorough review of all the possible effects of going on testosterone. Grayson was informed about the possibility of future infertility and how he might want to consider freezing his eggs before going on testosterone. He was also told about how testosterone would likely lower his voice, might cause him to experience heightened emotions, would cause him to grow facial and body hair, could give him more acne, and would have other effects. Grayson and I both were made aware that many of these changes would likely be permanent. The doctor also required us to provide proof of a gender dysphoria diagnosis. Grayson

assented to the risks and benefits. I also consented to the treatment because I had seen how Grayson had struggled with gender dysphoria and trusted the doctor's ability to provide comprehensive care for my child. We have regular visits with the doctor to monitor Grayson's health now that he is on testosterone.

18. As a parent I have always put the health and safety of my child first, and after doing much research on my own and consulting with Grayson's doctor, I know that getting this care is necessary for Grayson's health. Grayson and I together have made this decision and could not be happier with the results.

19. Since starting testosterone in April 2023, I have witnessed a massive positive shift in Grayson's mental health. He is now much more social, energetic, and spending more time outside of his room. He no longer seems depressed and anxious all the time, has not engaged in self-harm and has not had thoughts of self-harm, which is probably the biggest relief for me. He is happy and healthy because he is receiving the care he needs and that care is allowing him to be and live as his authentic self. Seeing him blossom and the improvement in his mental health has meant everything to me as a mother.

20. Since we learned of S.B. 14, my whole family has been impacted on some level. Should S.B. 14 go into effect, I am extremely worried about what will happen to my son's physical and mental health if his health care is taken away from him. I have seen first-hand how Grayson was prior to receiving treatment and I know this health care is not only saving his life but making his life possible. It has only had positive impacts on Grayson. I just cannot imagine being back in the place we were, where Grayson was suffering so much, experiencing thoughts of self-harm, and engaging in self-harm. But that is exactly what will happen. Grayson does not want to experience those feelings again and I do not want him to. Nor do I want to experience the worry, concern, and

helplessness I felt as his mother, watching him suffer, until we finally figured out what he needed and got it for him.

21. I just want Grayson to remain happy, healthy, and able to envision a future for himself, like he has been since receiving gender-affirming health care.

22. I certainly do not have the financial means to travel back and forth between Texas and a neighboring state where we could get Grayson the care he needs. Our only option would be to move, which is also not something we want, and which would be financially very difficult. I pay out-of-pocket for Grayson's gender-affirming medical care. Texas is where our home is, our community, jobs, family, and friends. It is all Grayson has ever known and he does not want to move, none of us do.

23. S.B.14 threatens the continued mental and physical well-being of my child and ultimately his life. That is just not something I can accept for my child when I know that I, and his providers, have done the best we can, and we have seen the positive impact on Grayson.

24. My legal name is [redacted], my date of birth is [redacted]. My address is [redacted]. I declare under penalty of perjury that the foregoing is true and correct.

Executed in McLennan County, State of Texas, on Jul 9, 2023.

[redacted]

[redacted]

Gina Goe

Gina Goe (Jul 9, 2023 15:05 CDT)

Gina Goe

Exhibit 8

CAUSE NO.

LAZARO LOE, *et al.*,	§	
Plaintiffs,	§	
v.	§	IN THE DISTRICT COURT OF
	§	TRAVIS COUNTY, TEXAS
THE STATE OF TEXAS, *et al.*,	§	____ JUDICIAL DISTRICT
Defendants.	§	

AFFIDAVIT OF RICHARD OGDEN ROBERTS III, MD, MPH

I, Richard Ogden Roberts III, MD, MPH, hereby declare and state as follows:

1. I am over 18 years of age, of sound mind, and in all respects competent to testify.

2. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and competently as to those facts.

3. I am a Plaintiff in this action. I am asserting claims on behalf of myself and my patients.

4. I am a pediatric endocrinologist living in Texas.

5. I am a member of GLMA: Health Professionals Advancing LGBTQ+ Equality, as well as of the American Academy of Pediatrics, the Pediatric Endocrine Society, and the World Professional Association for Transgender Health ("WPATH").

6. I obtained my medical degree from the University of Virginia School of Medicine in 2014. I completed my internship and residency in general pediatrics in 2015 and 2017, respectively, at the University of California – Los Angeles and UCLA Mattel Children's Hospital. Following my residency, I completed my fellowship in pediatric endocrinology at the University of Colorado Anschutz Medical Campus and Children's Hospital Colorado in 2020.

Throughout medical school, residency, and fellowship programs, I received training and obtained clinical experience in the provision of gender-affirming health care to gender-diverse youth.

7. I also have a master's in public health focusing in epidemiology from Tulane University School of Public Health and Tropical Medicine, which I obtained in 2010.

8. I am double board certified by the American Board of Pediatrics in General Pediatrics and Pediatric Endocrinology. I am licensed to practice medicine in the State of Texas. I have previously been licensed to practice medicine in the States of California and Colorado.

9. Following the completion of my fellowship, I became an Assistant Professor in the Department of Pediatrics, Division of Diabetes and Endocrinology at Baylor College of Medicine in Houston, Texas, where I instruct medical students, residents, and fellows in the field of pediatric endocrinology. This declaration reflects my personal opinions and beliefs, and is not made as a representative of Baylor College of Medicine.

10. As a pediatric endocrinologist, among the care I provide is care for transgender adolescents and gender diverse children.

11. Over the course of my medical career, including my residency and fellowship, I have provided health care services and treatment to over 200 gender diverse and transgender young people and their families, and currently provide care to approximately 100 patients of varying ages, up to adulthood (over the age of 18 years).

12. I became interested in providing gender-affirming medical care after encountering transgender patients with gender dysphoria during my medical training in Virginia, California, and Colorado. As I interacted more with this population, I saw that there was a need for providers who were competent in this care.

13. Since 2020, I have served as BCM/TCH Division of Endocrinology Transgender Care Co-Lead, and as of 2023, I have served as the co-Medical Director of the Transgender Care Program, which encompasses the multidisciplinary nature of gender-affirming care, at Texas Children's Hospital. This declaration reflects my personal opinions and beliefs, and is not made as a representative of Texas Children's Hospital.

14. In my capacity as a pediatric endocrinologist at Texas Children's Hospital, I provide evidence-based care for gender dysphoria, which is informed by widely accepted clinical practice guidelines such as the *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, which is peer-reviewed and was published by WPATH in 2022, and *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, which is peer-reviewed and was published by the Endocrine Society in 2017. We also use the diagnostic criteria for "Gender Dysphoria in Adolescents and Adults" set forth in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR), published by the American Psychiatric Association in 2013 and revised in 2022.

15. In my practice, patients with gender dysphoria are treated by a multidisciplinary team that includes mental health providers such as psychologists and psychiatrists, pediatric endocrinologists, adolescent medicine physicians, and pediatric surgeons, amongst other health professionals. This approach is consistent with the multidisciplinary approach for the treatment of adolescents recommended by the WPATH Standards of Care, Version 8. Our approach to care is individualized and focuses on the particular needs of each patient and their family.

16. When treating transgender patients under 18, consistent with clinical practice guidelines, I require that the patient have a gender dysphoria diagnosis under criteria set forth in

the DSM-5-TR and that they have been properly assessed prior to initiating medical treatment. Additionally, the intake process with transgender patients under 18 always includes the patient's parents who are required to provide consent on behalf of their child for all medical treatment after being informed of the risks and benefits of treatment.

17. When transgender patients with gender dysphoria reach the onset of puberty, I provide them with puberty-delaying medications if such treatment is medically indicated for the patient. Puberty-delaying medications may be provided in the form of an implant (histrelin acetate) or injection (various forms exist and the specific medication used is largely dictated by insurance formularies). This treatment pauses puberty and provides the young person more time to understand their gender identity without having to experience the anxiety and distress associated with developing undesired secondary sex characteristics that do not align with their gender identity. It also provides the patient and their family with more time to work together, along with their providers, to decide on the best long-term course of appropriate medical treatment for the young person.

18. For patients whose gender identity has been persistent and consistent, I provide gender-affirming hormone therapies (testosterone suppression and estradiol for transgender girls and menstrual regulation and testosterone for transgender boys) with the adolescent patients and their families, and initiate such treatment if medically indicated. The purpose of this treatment is to affirm the patient's gender identity and provides pubertal development of secondary sexual characteristics of the transgender patient to achieve a physical development that more closely aligns with their gender identity. Eligibility and medical necessity are determined case-by-case, based on an assessment of the adolescent's unique cognitive and emotional maturation and ability to provide a knowing and informed assent. The decision to initiate hormone therapy

would be made only after a careful review with the adolescent and parents/guardians of the potential risks and benefits of hormone therapy.

19. Some patients are never treated with pubertal suppression because they arrive already well into their endogenous puberty and are only evaluated for gender-affirming hormones like testosterone or estrogen. Others are evaluated and treated first with pubertal suppression and then assessed for gender-affirming hormones. Again, each patient's treatment depends on their individual medical and mental health needs.

20. No medical treatments for gender-affirmation are indicated or provided for pre-pubertal children (i.e., children who have not yet reached puberty) with gender dysphoria.

21. When patients inform me that they are moving out of the area or even state, I provide them with information about clinics and providers that provide gender-affirming medical care for transgender adolescents with gender dysphoria wherever they are moving. I consider it part of my obligation to care for my patients to maintain continuity of care by helping them find care they need if I am unable to continue providing such care.

22. Some of the same treatments I provide to my transgender patients with gender dysphoria, I also provide to cisgender patients, based on their particular health needs. Indeed, gender-affirming care is a small portion of my medical practices, and only comprises approximately 10-20% of my clinical time.

23. As a pediatric endocrinologist, I treat patients with puberty blockers for both precocious puberty and gender dysphoria, and in both cases, the side effects are comparable and typically easily managed. Depending on the clinical scenario for each patient population, the risks are typically outweighed by the benefits of treatment. When providing this treatment, I counsel my patients with gender dysphoria as well as those with precocious puberty similarly

regarding any side effects, which are present when the treatment is provided regardless of which condition.

24. As a pediatric endocrinologist, I treat patients with hormonal therapies (testosterone or estradiol), menstrual regulation, or testosterone-blockers for various endocrinopathies as well as for gender dysphoria, and in both cases, the side effects are comparable and typically easily managed. For example, in my general pediatric endocrinology practice, I provide testosterone suppressants to treat cisgender girls with polycystic ovarian syndrome, which can cause symptoms such as facial hair growth. In such cases, this treatment is also to affirm the gender of cisgender patients. I also provide hormonal contraception, which can be used to regulate one's cycle and/or for ovulation suppression, to cisgender patients who might have heavy periods or other health risks associated with regular uterine bleeding. I also provide hormones to initiate pubertal development and maintain sex steroid concentrations in individuals with hypogonadism (inability to secrete sex steroids) such as primary ovarian insufficiency, Turner Syndrome or Klinefelter Syndrome, amongst others. The safety profile and side effects of these medications do not differ based on the condition for which they are provided as treatment.

25. In each of the above circumstances, patients are closely monitored for and counseled about potential side effects. The monitoring parameters and recommendations for patients with gender dysphoria are quite extensive and conservative, and are enumerated in each of the previously discussed practice guidelines. It is advised under these guidelines to monitor for side effects both physically and biochemically in a clinically appropriate manner. I follow patients closely and monitor my patients' risks of side effects at each visit. Laboratory evaluations are obtained as clinically appropriate.

26. As a result of Senate Bill 14 (hereafter "SB 14" or "the Ban"), healthcare providers, like myself, will no longer be able to continue gender-affirming medical care absent an injunction preventing SB 14 from taking effect.

27. In announcing its decision to modify the care it offers to transgender adolescents with gender dysphoria in order to comply with SB 14, a statement released by Texas Children's Hospital described the decision to make the modifications as "heart-wrenching" and emphasized that its mission is "to create a healthier future for **all** children." To be sure, Texas Children's remains "dedicated to educating and amplifying the importance of safe, high-quality transgender medicine programs." I agree with these statements, specifically that the implementation of SB 14 will restrict the access of a small and vulnerable portion of the pediatric population to safe, high-quality, well-informed, and monitored healthcare.

28. If SB 14 takes effect, I will be required to either fully comply with the law and therefore be unable to provide my patients with the medical care they need or risk losing my medical license, which will not only deprive me of the ability to provide medical care to all of my patients but also negatively impact my livelihood. I understand that unless enforcement of the law is enjoined, beginning September 1, 2023, I will be barred from providing medical therapies to treat gender dysphoria in my adolescent patients. Furthermore, it is my understanding that I may "wean off" adolescent patients who are already receiving treatment for gender dysphoria as of June 1, 2023, and who meet a set of criteria set forth by the Ban, though SB 14 does not specify any time period by which this needs to be accomplished.

29. While I anticipate that a few of my current minor patients will be able to continue to receive care outside Texas after September 1, 2023, many of my patients are unable to do so for a variety of reasons, including a lack of financial resources. Indeed, a significant number of

my patients are on Medicaid or the Children's Health Insurance Program, which SB 14 prohibits from covering gender-affirming medical care.

30. If SB 14 takes effect, I will be prohibited from providing puberty-delaying medications and gender-affirming hormone therapy to my transgender patients not only at my current place of employment, but also throughout the State of Texas, because such treatments relate to "transitioning" or "affirming the child 's perception of the child 's sex if that perception is inconsistent with the child 's biological sex," as defined by SB 14. However, I will be able to continue providing the same treatments to my cisgender patients to treat other conditions, which is discriminatory and forces me to violate my ethical guidelines and nondiscrimination laws.

31. SB 14 is in direct conflict with the oath I swore as a doctor and many of the rules, regulations, and statutes that I am required to follow. This has personally caused my colleagues and me a great deal of distress and confusion, as it is unclear how we can comply with the Ban without violating either current medical, ethical, or legal standards of care. The Ban forces my colleagues and me into the untenable position of deciding between fulfilling our oaths to provide our patients with the evidence-based medical care that they need or risking my license to practice medicine, along with other disciplinary action and penalties.

32. The Ban is also demeaning and shameful. It seeks to treat evidence-based, safe, and effective medical care for transgender people in a discriminatory manner that is arbitrary and completely at odds with clinical practice guidelines and the practice of medicine more generally. The Ban is in direct contradiction with our obligations as physicians and health care providers. We have an obligation to treat all patients in a manner consistent with their best interests to achieve the best possible health results for our patients.

33. As a medical provider of minor patients who experience gender dysphoria, I have developed a close relationship with both my patients and their families. Seeking and receiving treatment for gender dysphoria is a profoundly personal and informed decision based on a person's innermost sense of self and individual needs. It is also a subject that remains very misunderstood by the public at large. As a result, many of my patients require complete privacy, and I believe that as a medical provider, it is my duty and obligation to advocate on behalf of those patients who are unable to publicly advocate for themselves.

34. Based on my personal experience in treating adolescents with gender dysphoria, I believe that SB 14, if permitted to take effect, will significantly and severely compromise the health of my patients. My experience leads me to believe that denying my patients access to gender-affirming medical treatment can lead to worsening depression, increased anxiety, and possibly lead to suicidal ideation. As such, I am gravely concerned about my patients' ability to survive, much less thrive, if SB 14 takes effect.

35. To be sure, SB 14 impacts my patients in multiple ways. Not only does SB 14 directly prohibit the provision of evidence-based, safe, and effective gender-affirming medical care, it also indirectly prohibits it by barring the expenditure of public money to any health care provider that provides or facilitates the provision of gender-affirming medical treatment.

36. In addition, SB 14 directly blocks Medicaid and CHIP from covering gender-affirming medical treatment, even if such treatment is medically necessary for the patient. As noted above, I have patients who receive their health coverage through Medicaid or CHIP and this provision would bar them from obtaining the care that they need on top of the general prohibition set forth in SB 14.

37. Being forced to deny my patients evidence-based care that is medically indicated for them and is often lifesaving for some patients violates the tenets of my profession by leaving my patients to suffer needless pain.

38. For patients currently on gender-affirming medical treatment as of June 1, 2023, my concerns are not alleviated by the provision in SB 14 that allows for some patients to have a "wean off" period of gradually decreasing their existing regimens for puberty-blocking medication or hormones. While tapering down may prevent some of my patients from suffering the most severe side effects from the abrupt withdrawal of their medications, providing my patients with sub-therapeutic doses of puberty-blocking medication or hormones would be inconsistent with the evidence-based medicine that I practice.

39. Once my patients begin to 'wean off" of puberty-blocking medication, they will begin endogenous hormonal puberty inconsistent with their gender identity. I would fully expect their gender dysphoria to worsen as they begin to develop secondary sex characteristics inconsistent with their gender.

40. Similarly, as my transgender adolescent patients who are receiving hormone therapy begin to "wean off," I anticipate that their gender dysphoria will increase: the hormone therapy they take brings their bodies into alignment with their gender identity, reducing the distress from the incongruence.

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

Executed on this 10 day of July 2023.

Richard Ogden Roberts III, MD, MPH

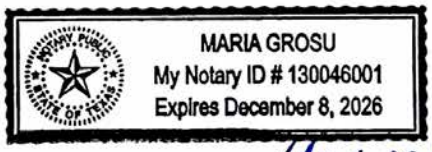
JURAT

State of Texas)
)
County of HARRIS)

Before me, a notary public, on this day personally appeared, Richard Ogden Roberts III, known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the foregoing instrument, and being first duly sworn by me states that the statements contained in the foregoing are true and correct to the best of his knowledge, information, and belief.

Sworn to and subscribed before me on the 10 day of July 2023, by Richard Ogden Roberts III.

IN TESTIMONY WHEREOF, I have set my hand and affixed my official seal on the day and year first written above.



Maria Grosu
Notary Public

Exhibit 9

CAUSE NO.

LAZARO LOE, *et al.*,	§	
	§	
Plaintiffs,	§	
v.	§	IN THE DISTRICT COURT OF
	§	TRAVIS COUNTY, TEXAS
THE STATE OF TEXAS, *et al.*,	§	____ JUDICIAL DISTRICT
	§	
Defendants.	§	
	§	

AFFIDAVIT OF DAVID LEO PAUL, M.D.

I, David Leo Paul, M.D., hereby declare and state as follows:

1. I am over 18 years of age, of sound mind, and in all respects competent to testify.

2. I have personal knowledge of the facts set forth in this Declaration and could and would testify competently to those facts if called as a witness. The views expressed herein are my own and not necessarily the views of my employer.

3. I am a Plaintiff in this action. I am bringing claims on behalf of myself and my patients.

4. I am a pediatric endocrinologist living in Texas.

5. I am a member of GLMA: Health Professionals Advancing LGBTQ+ Equality, as well as the Endocrine Society and Pediatric Endocrine Society.

6. I obtained my medical degree from University of Texas at San Antonio in 1984, after which I completed my residency in pediatrics at Wilford Hall U.S. Air Force Medical Center, Lackland Air Force Base in San Antonio, followed by a clinical fellowship in pediatric endocrinology at the University of California – San Francisco.

7. I am board-certified in pediatric endocrinology and am licensed to practice medicine in Texas.

8. I am currently an associate professor of pediatrics, diabetes, and endocrinology at Baylor College of Medicine in Houston, and I am on the faculty of Texas Children's Hospital. This declaration reflects my personal opinions and beliefs, and is not made as a representative of Baylor College of Medicine or Texas Children's Hospital.

9. I served 28 years in the United States Air Force and retired as a lieutenant colonel in 2012. During my time in the service, I was chief of pediatric endocrinology at Keesler Air Force Base Medical Center in Biloxi, Mississippi; at David Grant U.S. Air Force Medical Center at Travis Air Force Base in Fairfield, California; and at San Antonio Military Medical Center.

10. In 2007 and 2008, I was deployed with NATO forces in Afghanistan, where I was the sole pediatrician at Bagram Air Base. There, I was responsible for the care of civilian pediatric patients in the trauma and burn units, as well as the intensive care unit (ICU).

11. The first patient I treated for gender dysphoria was in 2007 while I was chief of pediatric endocrinology at San Antonio Military Medical Center. That patient was a 15-year-old transgender girl who, prior to entering my care, had been dosing herself with estrogen without a prescription. I familiarized myself with the WPATH Standards of Care and began to manage her hormone therapy to ensure the safety of her medical transition. As an endocrinologist, I was already familiar with providing this same treatment to cisgender patients with various conditions related to abnormal puberty. It was around then that I realized that gender-affirming medical care is simply standard medicine.

12. After a few years, when that patient stopped coming to my clinic, I assumed that she had just aged out and started seeing a provider for adults. Years later, that patient's sister reached out to me and informed me that my patient had died by suicide after learning that she was HIV positive.

13. Thankfully, I have not lost another patient to suicide since then. If SB 14 takes effect, I fear that more young Texans will, like my first patient with gender dysphoria, either take their gender-affirming health care into their own hands, by obtaining medications from questionable sources and dosing at potentially unsafe levels, or engage in self-harm including suicide just because they have a stigmatized medical condition.

14. When I arrived at Texas Children's in 2012, patients with gender dysphoria were typically referred to a doctor in Galveston who was double certified in psychiatry and pediatric endocrinology. It was important to me to be able to provide this care to our patients closer to home. I also knew that the doctor in Galveston was approaching retirement.

15. In my 11 years at Texas Children's, I have treated approximately 198 patients for gender dysphoria. In that same time, I have seen well over 15,000 patients total. A significant number of my patients receive coverage for their medical care through Medicaid or CHIP.

16. As part of my practice, I provide puberty-delaying treatment to transgender patients with gender dysphoria after the onset of puberty, if such treatment is medically indicated for the patient. This treatment pauses puberty and provides the young person more time to understand their gender identity without having to experience the anxiety and distress associated with developing undesired secondary sexual characteristics that do not match their gender identity. It also provides the patient and their family with more time to work together, along with their providers, to decide on the best long-term course of appropriate medical treatment for the young person.

17. For patients whose gender identity has been persistent and consistent, I explore gender-affirming hormone therapy (testosterone suppression or blocking and estrogen for transgender girls and estrogen suppression or blocking and testosterone for transgender boys) with

the adolescent patients and their families, usually beginning around the age of 14, and initiate such treatment if medically indicated. The purpose of this treatment is to attain the appropriate masculinization or feminization of the transgender person to achieve a gender phenotype that matches as closely as possible to their gender identity.

18. Eligibility and medical necessity are determined case-by-case, based on an assessment of the adolescent's unique cognitive and emotional maturation and ability to provide a knowing and informed assent. The decision is made only after a careful review with the adolescent and parents/guardians of the potential risks and benefits of hormone therapy, both short-term and long-term, and including potential impacts on fertility.

19. When I first see a patient seeking puberty blockers or hormone therapies, I conduct an assessment that is often as long as three hours to ensure that these treatments are medically indicated. Before starting these treatments, I also make certain that the patient has started puberty, either by reviewing other providers' notes, or by conducting a physical exam or reviewing bloodwork.

20. I regularly treat cisgender patients who have precocious puberty with the same puberty suppressing medications I use for my transgender patients. I also regularly treat cisgender patients who have delayed puberty or hypogonadism with the same hormone therapies.

21. If SB 14 takes effect, I will be barred from treating my transgender patients with gender dysphoria in accordance with the accepted standards of care. I will thus knowingly be causing harm to my patients by following Texas law. If I were to follow the medically indicated protocols for treating gender dysphoria, I could lose my license and my livelihood and face other disciplinary action and penalties.. However, under SB 14, I would be able to continue providing the same treatments to my cisgender patients to treat other conditions, which is discriminatory and

violates my ethical obligations and nondiscrimination laws. SB 14 thus puts me in an untenable situation as a healthcare provider.

22. If SB 14 is blocked from going into effect and being enforced, I would be able to continue practicing medicine to all of my patients based on the standards of care and my clinical judgment without the specter of losing my medical license for providing my patients with the best medical care possible.

23. In my years of treating patients with gender dysphoria, I have routinely heard from my patients and their parents that accessing gender-affirming care has dramatically improved my patients' wellbeing and quality of life.

24. If my patients with gender dysphoria are prohibited from accessing the medically necessary and lifesaving care in the State of Texas, I fear that they will experience severely negative physical and health outcomes, up to and including death. When not properly treated, my patients' gender dysphoria negatively affects their ability to establish and maintain healthy relationships, as well as their academic performance. If they lose access to gender affirming care, I know that my patients' entire worlds will be disrupted at a critical time in adolescence and the progress they have made in leading healthy, successful lives will be erased.

25. Unless SB 14 is enjoined, I will be prohibited from providing puberty-blocking medication or hormones to treat gender dysphoria in my adolescent patients. While I understand that I may "wean off" my adolescent patients who are already receiving treatment for gender dysphoria as of June 1, 2023, and who meet a set of criteria set forth in SB 14, the Ban does not specify any time period by which this needs to be accomplished. Thus, the provision of SB 14 that would require my patients to "wean off" their puberty-blocking or hormone replacement medications is of no help.

26. Providing my patients with doses of puberty-blocking medication or hormones below what would be medically indicated for them would be inconsistent with the evidence-based medicine that I practice, as well as unsafe and inappropriate for my patients.

27. For example, if patients begin receiving sub-therapeutic doses of puberty-delaying medications, they will begin endogenous hormonal puberty inconsistent with their gender identity. As such, I would expect my patients' gender dysphoria to worsen as they begin to develop secondary sex characteristics inconsistent with their gender identity. Similarly, as my transgender adolescent patients who are receiving hormone therapy begin to take sub-therapeutic doses, I anticipate that their gender dysphoria will increase: the hormone therapy they take brings their bodies into alignment with their gender identity, reducing the distress from the incongruence.

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

Executed in Houston, Texas, this 11th day of July 2023.

David Leo Paul
C0E2ADD8CC
Signed on 2023/07/11 16:07:08 -6:00

David Leo Paul, M.D.

JURAT

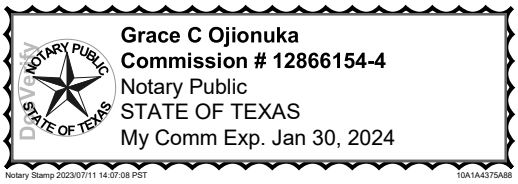
State of TEXAS)
)
County of HARRIS)

Before me, a notary public, on this day personally appeared, Patrick W. O'Malley, known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the foregoing instrument, and being first duly sworn by me states that the statements contained in the foregoing are true and correct to the best of his knowledge, information, and belief.

Sworn to and subscribed before me on the 11th day of July 2023, by Patrick W. O'Malley.

IN TESTIMONY WHEREOF, I have set my hand and affixed my official seal on the day and year first written above.

Notary Public, State of Texas



Notarial act performed by audio-visual communication

Exhibit 10

CAUSE NO.

LAZARO LOE, *et al.*, *Plaintiffs*, v. THE STATE OF TEXAS, *et al.*, *Defendants*.	§ § § § § § § § § § §	IN THE DISTRICT COURT OF TRAVIS COUNTY, TEXAS ____ JUDICIAL DISTRICT

AFFIDAVIT OF PATRICK W. O'MALLEY, M.D., M.P.H.

I, Patrick W. O'Malley, M.D., M.P.H., hereby declare and state as follows:

1. I am over 18 years of age, of sound mind, and in all respects competent to testify.

2. I have personal knowledge of the facts set forth in this Declaration and could and would testify competently to those facts if called as a witness.

3. I am a Plaintiff in this action. I am bringing claims on behalf of myself and my patients.

4. I am a psychiatrist specializing in children and adolescents living in Texas.

5. I am a member of GLMA: Health Professionals Advancing LGBTQ+ Equality, as well as the American Academy of Child and Adolescent Psychiatry and the World Professional Association for Transgender Health ("WPATH").

6. In 2017, I obtained my medical degree from Texas Tech University Health Sciences Center El Paso Paul L Foster School of Medicine and my Master of Public Health from the University of Texas Houston. I completed my residency in the Department of Psychiatry at University of Texas Southwestern Medical Center, followed by a fellowship in child and adolescent psychiatry at the Baylor College of Medicine, Menninger Department of Psychiatry and Behavioral Sciences.

7. I am board certified in psychiatry and am licensed to practice medicine in Texas. I am eligible for board-certification in child and adolescent psychiatry and will sit for my board exam this September.

8. Since 2022, I have been an assistant professor at Baylor College of Medicine, where I teach general psychiatry and child psychiatry, and I am a child psychiatrist at Texas Children's Hospital. As part of that work, I travel from Houston to Uvalde once a month to treat kids affected by the May 2022 mass shooting at Robb Elementary School. This declaration reflects my personal opinions and beliefs, and is not made as a representative of Baylor College of Medicine or Texas Children's Hospital.

9. As a child psychiatrist at Texas Children's, my patients tend to be those with more acute mental health conditions, such as severe depression or suicidality, and are usually referred to me by other providers because they are in need of a higher level of care. At least 50% of my job is running the intensive outpatient program.

10. I frequently treat patients with gender dysphoria who present with treatment-resistant anxiety and/or depression, meaning that the patient continues to experience clinically significant symptoms of anxiety and/or depression despite being treated with psychotherapy and psychiatric medications. In cases like these, it is my experience that gender-affirming medical care is often the only option to resolve those residual symptoms.

11. Approximately 20% of my practice involves treating gender dysphoria in kids. This care includes psychotherapy, psychiatric medication management, and family consultation, working with families to become open and curious about their kid's gender. My approach requires meeting families where they are and being open and accepting to where the family is. Often the child and their parents have very different views about gender. After doing an assessment with the

child and gathering medical history from the family, I present the family with what we know about gender dysphoria in adolescents. I often find myself working with families who haven't discussed gender at all, though it may have been an elephant in the room. I am the person there to say, "let's talk about the elephant in the room."

12. In my initial meetings with parents of kids with gender dysphoria, we talk about their knowledge and experience of gender and gender roles, what they've seen with their child's gender presentation, and explore cultural beliefs and traditions that they value related to gender. The goal is to foster an open, honest, and supportive discussion about what their child has experienced, and to encourage parents to be curious about their child's experience, to want to know more about what's going on with their child.

13. When addressing my patients gender dysphoria, I typically work collaboratively with other colleagues within and outside my institution to manage and treat the adolescent patient's gender dysphoria. For example, I regularly consult with colleagues such as Dr. David Paul and Dr. Richard Ogden Roberts, who are also plaintiffs in this case, when my patients require or are obtaining medical interventions such as puberty-delaying medications and gender-affirming hormones. I also regularly receive referrals from Drs. Paul and Roberts when patients of theirs are in need of psychiatric care.

14. I often see youth who are interested in pursuing medical treatment for their gender dysphoria. Consistent with the *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, published by the World Professional Association for Transgender Health ("WPATH"), sometimes there is a need to address, though not necessarily resolve, an adolescent patient's depression, suicidality, or other mental health condition, which may or may not be related to their gender dysphoria, prior to initiating gender-affirming medical treatment. In

addition, I sometimes work collaboratively with colleagues within and outside my institution when an adolescent requires a more comprehensive assessment prior to initiating medical treatment for their gender dysphoria, or when they require management and concurrent treatment of other mental health conditions while being treated for gender dysphoria.

15. As a psychiatrist I thus regularly work in a multidisciplinary manner with colleagues, both within and outside Texas Children's, who provide gender-affirming medical care such as puberty-delaying medications and hormones, including by making assessments, providing consultations, and if necessary, writing assessment letters documenting a patient's gender dysphoria and suitability for medical treatment for gender dysphoria if required by insurance or other providers.

16. In addition, Texas Children's, where I am psychiatrist, receives state funding in many ways including, but not limited to, through Medicaid and Children's Health Insurance Program ("CHIP") payments for patients' necessary and lifesaving health care. Indeed, I see numerous young patients who receive coverage for their medical care, including for gender dysphoria, through Medicaid or CHIP.

17. Supporting transgender youth in the State of Texas by facilitating the provision of gender-affirming medical care is deeply important to me and is central to my relationships with my patients with gender dysphoria. Being a psychiatrist specializing in the treatment of children and adolescents means that I work with those youth who are most at risk for suicide, including some who are transgender, and keeping these young people alive is my number one goal.

18. While as a psychiatrist I do not directly provide, prescribe, administer, or dispense the medical interventions prohibited by SB 14, I understand that SB 14 prohibits the expenditure of public money to directly or indirectly be used, granted, paid, or distributed to any health care

provider, medical school, hospital, physician, or individual that facilitates the provision of a procedure or treatment prohibited by SB 14.

19. If SB 14 is allowed to take effect, then I would be incapable of providing my adolescent patients with gender dysphoria with the care that they need as I would be barred from working collaboratively with other providers to effectively manage and treat an adolescent's gender dysphoria, including in the ways described above, as such actions could be considered facilitation of the provision of a procedure or treatment barred by SB 14.

20. SB 14 thus prevents me from providing my transgender adolescent patients with gender dysphoria with the optimal and evidence-based care that they need and deserve. As a psychiatrist, I have seen how the gender-affirming medical interventions prohibited by SB 14 have greatly improved the mental health, wellbeing, and quality of life of my transgender patients. Conversely, I have observed how lack of access to gender-affirming medical interventions, when indicated for the patient, has led to the deterioration of my transgender patient's mental health and wellbeing.

21. I worry what will happen to my patients with gender dysphoria if SB 14 is allowed to take effect.

22. In my experience, some of my transgender adolescent patients present with depression or anxiety independent of their gender dysphoria and treating one condition will not necessarily resolve the other, while some of my transgender adolescent patients' anxiety or depression may be related to and in fact be caused by their gender dysphoria. Treatment for anxiety or depression in those circumstances would be treating a symptom, and not the condition. Without access to gender-affirming medical care, neither the anxiety or depression, nor the gender dysphoria would be fully addressed. In addition, by barring the provision of gender-affirming

medical interventions, SB 14 may lead to over-prescription of medication to treat co-occurring mental health conditions like depression or anxiety as in many instances, gender-affirming medical treatment results in the diminution or resolution of a patient's anxiety or depression, such that they do not need additional medications.

23. What is more, because the nature of my work is to treat those patients with the most acute symptoms, interruptions or discontinuations in their care would be particularly devastating, even life-threatening, to my patients. I have already had patients come to me worried about this law, worried that their symptoms will worsen if they lose access to care.

24. If SB 14 is allowed to take effect, I will be in the position of working with patients who cannot access the care they need to fully address their mental health conditions. I will bear witness to current patients' mental health deteriorating. The intensive outpatient unit I run will take on more patients because of untreated gender dysphoria and the resultant upticks in anxiety, depression, and suicidality. All of that would take a toll on me as a provider and as a person.

25. I am especially concerned for those of my patients who are insured through Medicaid and CHIP, both because they are already more likely to experience adverse social determinants of health and because they are much less likely to be able to travel out of state to continue their gender affirming medical care. When I was choosing where to work, it was really important to me that I would be able to provide care to patients with Medicaid. I consider it part of my duty as a physician to provide care to as wide a swath of the community as possible.

26. I am not at all reassured by the provision of SB 14 that requires certain patients to "wean off" their medications "over a period of time and in a manner that is safe and medically appropriate." To the contrary, there is no safe and medically appropriate time or manner in which

to wind down this medically necessary treatment, without risking exacerbating the patient's gender dysphoria and harming their mental health and wellbeing.

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

Executed in Houston, Texas, this 11th day of July, 2023.

Patrick O'Malley
Signed on 2023/07/11 16:18:41 -6:00

Patrick W. O'Malley, M.D., M.P.H.

JURAT

State of Texas)
)
County of Harris)

Before me, a notary public, on this day personally appeared, Patrick W. O'Malley, known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the foregoing instrument, and being first duly sworn by me states that the statements contained in the foregoing are true and correct to the best of his knowledge, information, and belief.

Sworn to and subscribed before me on the 11th day of July 2023, by Patrick W. O'Malley.

IN TESTIMONY WHEREOF, I have set my hand and affixed my official seal on the day and year first written above.

Grace C Ojionuka
Commission # 12866154-4
Notary Public
STATE OF TEXAS
My Comm Exp. Jan 30, 2024

Notary Stamp 2023/07/11 14:18:41 PST 6A2B9D074785

Signed on 2023/07/11 16:18:41 -6:00

Notary Public, State of Texas

Notarial act performed by audio-visual communication

Exhibit 11

LAZARO LOE, *et al.*	§	**IN THE DISTRICT COURT OF**
Plaintiffs	§	**TRAVIS COUNTY, TEXAS**
v.	§	**_____ JUDICIAL DISTRICT**
STATE OF TEXAS, *et. al*,	§	
Defendants.	§	

AFFIDAVIT OF BRIAN K. BOND

I, Brian K. Bond, hereby declare and state as follows:

1. I am over 18 years of age, of sound mind, and fully capable of making this declaration. I have personal knowledge of the facts set forth in this declaration, they are true and correct, and I would testify competently to those facts if called to do so.

2. I am the Executive Director of PFLAG, Inc. ("PFLAG"). Founded in 1973, PFLAG is the first and largest organization for lesbian, gay, bisexual, transgender, and queer ("LGBTQ+") people, their parents and families, and allies. We are a 501(c)(3) non-profit organization.

3. PFLAG has over 350 chapters across the country and approximately 325,000 members and supporters nationwide. Our members and supporters cross multiple generations of families in major urban centers, small cities, and rural areas across America. PFLAG envisions an equitable and inclusive world where every LGBTQ+ person is safe, celebrated, empowered, and loved. Our mission is to create a caring, just, and affirming world for LGBTQ+ people and those who love them.

4. Our founder, Jeanne Manford, marched with her son Morty in the 1972 Christopher Street Liberation Day March in New York City and created the very first support group for parents and families of LGBTQ+ people in 1973. Supporting LGBTQ+ young people by supporting and strengthening their families has been a core part of our work ever since. Today, the gold-standard advocated by PFLAG parents and families—and set forth by pediatricians and therapists—is to accept, support, and affirm LGBTQ+ people's sexual orientation and/or gender identity and expression; parental rejection is widely understood to be abusive and damaging.

5. We know, too, that LGBTQ+ youth thrive when supported in their schools and community. So, our work also includes ending bullying, discrimination, and harassment in educational settings by providing training for teachers, administrators, and district leaders, and advocating in the public square to ensure LGBTQ+ people are treated fairly and equally when accessing public accommodations and health care.

6. We know that change happens and support grows one interaction at a time, one family at a time.

7. PFLAG is a national membership organization and we have local chapters in 49 states and the District of Columbia. Our chapters in Texas include PFLAG Amarillo, PFLAG Austin, PFLAG Beaumont, PFLAG Boerne, PFLAG Brenham, PFLAG Dallas, PFLAG El Paso, PFLAG Fort Worth, PFLAG Georgetown, PFLAG Houston, PFLAG Lubbock, PFLAG Mesquite, PFLAG Midland/Odessa, PFLAG Montgomery, PFLAG San Antonio, PFLAG San Marcos, PFLAG Seguin, and PFLAG Tyler/East Texas.

8. PFLAG's membership is comprised of chapter members and national members. Individuals can become a PFLAG member by joining the national organization directly or by

joining their local chapter, which sends a portion of the member's dues to PFLAG National, also making them national members. In addition to our formal members, PFLAG serves thousands of community members through our programs, events, and services every year.

9. PFLAG's members play a central role in electing our organizational leadership. Of the 21 members of the PFLAG National Board of Directors, seven are elected directly by our membership. Seven more are elected by the Regional Directors Council, a body of 13 volunteers who are themselves each elected by the members of one of PFLAG's thirteen regions to work with PFLAG National staff to provide support, resources, training, and help to start new affiliates, and to share the perspectives and activities of members with PFLAG National staff. The remaining seven are elected by the Board itself.

10. As Executive Director, I am the leader of the professional staff who carry out the work of the PFLAG National office, including supporting the development and work of the PFLAG Chapter Network and promoting PFLAG's presence in the national arena, including through policy advocacy, coalitions with organizations who share our goals, developing trainings and educational materials, and engaging with the media. Supporting the PFLAG Chapter Network is PFLAG National's largest program and our national staff works closely with chapter leaders and members across the country to reinforce their efforts to establish and grow their chapters, providing them with infrastructure, publications, online learning tools, advocacy support, media training, and countless other services and supports.

11. Because promoting the wellbeing of LGBTQ+ youth through encouraging and supporting love and affirmation by their families is a core part of our mission and because we have an extensive network of chapters and nearly 1500 members who live in Texas, we have been actively involved in supporting and providing resources to our members and constituents in

light of the increasingly hostile climate for transgender youth and their families in the state over the last few years. This includes PFLAG joining litigation on behalf of our members in order to protect them from Governor Abbott's directive deeming all affirming health care for transgender adolescents, regardless of medical necessity, to be "child abuse" and the Texas Department of Family and Protective Services' ("DFPS") subsequent adoption and implementation of that directive to investigate parents alleged to be helping their children access such care. Suddenly the very thing we know to be good for LGBTQ+ children—supporting and loving your child for who they are and ensuring they receive care they need to thrive—was a reason to be reported and subjected to an intrusive and traumatic investigation.

12. In September 2022, the Travis County District Court issued an injunction blocking DFPS from carrying out this directive, protecting PFLAG member families from investigation. Although the State appealed that injunction, the Court of Appeals reinstated its protections shortly thereafter. That case is still pending, but at least PFLAG families are presently protected from being investigated for child abuse based solely on allegations they sought medically necessary care for their transgender or nonbinary child.

13. This brief sigh of relief we felt from the DFPS Rule being enjoined ended when SB 14 was signed into law on June 2, 2023. PFLAG members had been actively engaged in fighting against SB14's passage, voicing their opposition regularly at the statehouse. Given the hostility of the climate in Texas towards transgender people in general, and toward youth in particular, its passage was met with both resignation at its predictability and tremendous fear. New families showed up in droves for chapter meetings and support groups, seeking information and support. Chapters planned and participated in events to provide comfort to and celebrate the unbreakable joy of the gender diverse community. PFLAG families with transgender and

nonbinary adolescents shared their contingency plans—those with the resources to move or seek care out of state have begun firming up their plans to do so, while the vast majority without those resources have been asking chapters for alternative avenues to maintain care in Texas. Families were not just seeking health care providers who specialize in medical care for gender dysphoria but leads on affirming general practitioners as well so that their adolescents would have access to multiple providers in the event that their primary providers stop providing gender-affirming medical care or leave the state as a result of SB14. Requests for mental health care providers have skyrocketed, as the fear, distress, and anxiety at the prospect of losing access to medically necessary care has exacerbated adolescents' existing mental health issues connected to their gender dysphoria. Parents and families are scrambling as their children's providers have cancelled appointments and begun winding down medical care for gender dysphoria because of SB14's imminent effective date. And chapter leaders have heard concerns about the impacts on transgender and non-binary youth in the foster care system, who receive health care coverage through Medicaid and will lose coverage for their medical care for gender dysphoria if SB14 goes into effect.

14. SB 14 subjects PFLAG's Texas members with a transgender or nonbinary child in need of gender-affirming medical care to a substantial risk of harm. PFLAG has members in Texas whose children are being or will be monitored for the appropriate time to begin puberty blockers, are currently or soon will be on puberty blockers, and are currently or soon will be on hormone therapy, all as part of a medically prescribed course of care for gender dysphoria. Some of those families are being harmed right now by SB 14's passage, whether because they have had appointments for scheduled care cancelled, are losing access to healthcare providers who are moving their practice out of state or ending their provisions of gender-affirming care for fear of

losing their medical licenses or state funding, or have otherwise had their imminent plans to obtain the established course of medically necessary care for their transgender or nonbinary children disrupted or foreclosed.

15. Other current and future PFLAG members with transgender or nonbinary children face a substantial risk of being harmed if SB 14 goes into effect, including being denied the right to make medical decisions for their child because the care their child's healthcare providers have declared medically necessary for them has been deemed unlawful, being prevented from obtaining the puberty blockers or hormone therapy their child needs solely because they are treatment for gender dysphoria, or losing coverage for care that has previously been covered under state funded health plans. SB 14 will force PFLAG families who have seen their children thrive as a result of medical care to treat their gender dysphoria to stop providing that care, putting those children at risk of serious mental and physical harm—the very reasons those families sought medical care in the first place.

16. While SB 14 has caused or will cause some PFLAG families to leave Texas entirely or to have to access the medically necessary care their transgender or nonbinary child needs in another state, the logistical and financial costs of doing so are incredibly high. No family should be forced to leave their home, jobs, or community or to split up their family to access the established course of medical care for their child's health condition, but SB14 is putting Texas PFLAG families in exactly that position. For countless others, those costs are simply too high; thus SB 14 leaves those transgender and nonbinary Texas youth and their families with no way to access the medically necessary care they need. Parents are prioritizing their children's mental and physical health, but SB14 will strip them of the ability to make the

decisions that they, their children, and their children's medical providers know are in their best interests. SB14 will put these adolescents' lives at risk.

17. Although these members could challenge SB 14 in their own right—as the other Plaintiff families are doing—PFLAG brings claims on behalf of its members to represent their interests to shield them from harm, to vindicate their rights to make the medical decisions they, their child, and their medical providers know to be in their child's best interests, and to allow them to maintain their focus on their child's health and wellbeing rather than litigation.

18. Representing the interests of these members in challenging SB 14 is directly connected to PFLAG's mission in two ways. First, that mission includes encouraging and supporting parents and families of transgender and gender non-conforming people in affirming their children and helping them access the social, psychological, and medical supports they need. We work with our families to encourage love and support of their transgender and gender non-conforming children and to help them ensure that the children's needs are met. The provisions of SB 14 send the opposite message and prevent families from meeting their child's needs. SB 14 bars families from supporting their child's affirmation of their gender identity by seeking the established medically necessary care that has been prescribed for them, depriving youth of medically necessary gender-affirming care, resulting in anxiety, depression, and other negative health outcomes associated with denying or cutting off medically necessary care. In order to fulfill our mission to our members, we must fight back against a law that prevents them from doing the very thing we encourage because we know it is in the best interests of the children.

19. Second, we teach our members to advocate for a caring, just, and affirming world where LGBTQ+ people are safe, celebrated, empowered, and loved, and to advocate for equitable laws and policies that protect them. We have spoken out against bans on medically

necessary care for youth with gender dysphoria such as SB 14 because they directly conflict with parents' abilities to act in their children's best interest and do nothing to protect the health and well-being of youth or anyone who needs access to medical care. SB 14 is the antithesis of an equitable law, interfering with and obstructing decisions made between PFLAG parents, their child, and their child's provider to deprive that child of care that is proven to be safe, medically sound, and necessary for treating gender dysphoria. As an organization dedicated to parents and families of LGBTQ+ youth, we cannot in good faith sit back as our members' fundamental rights to make decisions about their child's medical care are infringed solely because their child is transgender or nonbinary.

20. PFLAG exists to foster a world where LGBTQ+ children can become thriving, healthy, and happy LGBTQ+ adults. Our members depend on us to provide support and community for them in a society that often still treats their children as second-class citizens, attempts to silence them, or denies their very existence. For our members who have transgender and nonbinary children and are doing nothing more than loving them and following the advice of qualified medical professionals, PFLAG is here to do all we can to support them in those efforts and protect them from harmful, invasive laws like SB 14.

Brian K. Bond
Executive Director, PFLAG, Inc.

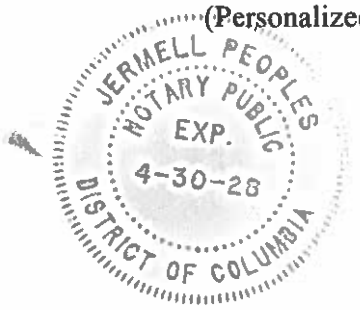
Notary Verification

District of Columbia

Brian K. Bond personally appeared before me, and being first duly sworn declared that he signed this declaration in the capacity designated, if any, and further states that he has read the above declaration and the statements therein contained are true.

Sworn to and subscribed before me on the 11th day of July 2023, by Brian K. Bond.

(Personalized Seal)



Notary Public's Signature

Exhibit 12

CAUSE NO.

LAZARO LOE, *et al.*,	§	
	§	
Plaintiffs,	§	
v.	§	IN THE DISTRICT COURT OF
	§	TRAVIS COUNTY, TEXAS
THE STATE OF TEXAS, *et al.*,	§	____ JUDICIAL DISTRICT
	§	
Defendants.	§	
	§	
	§	
	§	

AFFIDAVIT OF ALEX SHELDON, EXECUTIVE DIRECTOR OF GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ+ EQUALITY

I, Alex Sheldon, hereby declare and state as follows:

1. I am over 18 years of age, of sound mind, and in all respects competent to testify.

2. I go by they/them pronouns.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and competently as to those facts.

4. I offer this declaration in support of Plaintiffs' Motion for a Temporary Injunction.

5. I am the Executive Director of American Association of Physicians for Human Rights, Inc., d/b/a GLMA: Health Professionals Advancing LGBTQ+ Equality ("GLMA"), which is an organizational plaintiff in this case bringing claims on behalf of its members.

6. I am a professional researcher, strategist, and advocate with over 15 years of experience in the field of human rights, with a particular emphasis on LGBTQ+ rights. Prior to joining GLMA, I was the Head of Research & Social Impact at an LGBTQ+ start-up company, where I specialized in economic inclusion for LGBTQ+ people. Previously, I served as the Deputy Director of the Clinton Global Initiative (CGI) at the Clinton Foundation, and I held roles at

Everytown for Gun Safety, the Movement Advancement Project (MAP), and several international nonprofits.

7. GLMA is a 501(c)(3) national membership nonprofit organization based in Washington D.C. and incorporated in California. Founded in 1981, GLMA is the world's largest and oldest association of LGBTQ+ healthcare professionals. Our mission is to ensure health equity for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals, and equality for LGBTQ+ health professionals in their work and learning environments. To achieve this mission, GLMA utilizes the scientific expertise of its diverse multidisciplinary membership to inform and drive advocacy, education, and research.

8. GLMA was originally founded as the American Association of Physicians for Human Rights (AAPHR) and was an offshoot of the Bay Area Physicians for Human Rights (BAPHR), a San Francisco-based physician organization founded to fight discrimination faced by gay and lesbian physicians in the workplace based upon their sexual orientation. AAPHR was founded to take this mission to a national level. Its initial mission focused on responding with policy advocacy and public health research to the growing medical crisis that would become the HIV/AIDS epidemic.

9. Since being founded, GLMA's mission has broadened to address the full range of health concerns and issues affecting LGBTQ+ people, including ensuring that sound science and research inform health policy and practices regarding the LGBTQ+ community.

10. GLMA represents the interests of tens of thousands of LGBTQ+ and allied health professionals, as well as millions of LGBTQ+ patients and families. GLMA's membership includes approximately 1,000 member physicians, nurses, advanced practice nurses, physician assistants, researchers and academics, behavioral health specialists, health profession students, and other

health professionals. GLMA's members reside and work across the United States, including Texas, and in several other countries. Their practices represent the major health care disciplines and a wide range of health specialties, including endocrinology, internal medicine, family practice, psychiatry, obstetrics/gynecology, emergency medicine, neurology, and infectious diseases.

11. Different health care professionals can become and are members of GLMA. General membership in GLMA is open to health professionals and health professionals in training, as defined by GLMA's Board of Directors. These different memberships account for practicing health professionals of all disciplines and specialties, with various years of experience, as well as those who are retired and are students. Members who are health professionals or health professionals in training can serve as committee members and have the right to cast an advisory vote.

12. In addition to general members, GLMA has a "friend" membership for those individuals who are invested in LGBTQ+ health equity but are not directly involved in health professions. Unlike general members, these "health equity supporters" do not have the right to cast an advisory vote.

13. In addition to our formal members, GLMA serves thousands of people in the community through our programs, events, and services every year.

14. GLMA is also partners with the American Medical Association (AMA), the United States Preventative Services Task Force (USPSTF), the National Minority Health (NMH) Alliance, the Reproductive Health Coalition, the American Medical Student Association (AMSA), and the American Academy of Physician Assistants (AAPA), among other medical associations and health organizations.

15. As part of its mission to ensure health care equity for the LGBTQ+ community as well as equity for LGBTQ+ health care professionals, GLMA is committed to breaking down barriers to comprehensive care for the LGBTQ+ community. This includes GLMA's steadfast commitment to ensure that transgender individuals receive the gender affirming care they want, need, and deserve.

16. For example, in 2018, GLMA adopted a formal policy statement on "Transgender Healthcare." This policy statement (127-18-101-21 - Transgender Healthcare) was readopted in 2021. The policy statement reads: "GLMA: Health Professionals Advancing LGBTQ+ Equality considers therapeutic treatments, including hormone therapy, mental health therapy, vocal therapy, hair removal, and gender- affirming surgeries, as medically necessary for the purpose of gender-affirmation or the treatment of gender dysphoria or gender incongruence. These gender-affirming medical and surgical treatments should be covered by all public and private insurance plans."

17. In 2019, in conjunction with the American Medical Association, GLMA published an issue brief titled "Health insurance coverage for gender- affirming care of transgender patients." This brief discusses both the positive effects and outcomes of gender-affirming medical care for transgender patients, as well as the negative effects and serious health consequences that transgender patients are denied access to gender-affirming medical care when medically indicated for them. A copy of the issue brief is available at: https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf.

18. What is more, GLMA seeks to promote education and encourages research surrounding LGBTQ+ health issues, including the provision of gender-affirming medical care and study and treatment of gender dysphoria. As such, our Annual Conference on LGBTQ+ Health regularly includes numerous scientific abstracts and poster presentations on gender-affirming care

and the treatment of transgender patients. Since its inception in 1981, GLMA's Annual Conference on LGBTQ+ Health has served as the premier scientific conference for LGBTQ+ and allied health professionals to share innovative health care breakthroughs and interventions, as well as the latest research on LGBTQ+ health. The conference is open to health care providers of all disciplines, researchers, academics, health administrators, policy experts, and others interested LGBTQ+ health.

19. Because health care equity for the LGBTQ+ community as well as equality for LGBTQ+ health care professionals is our mission, we heard an immediate outcry from members and supporters following the passage of Senate Bill 14 ("SB 14" or "the Ban"), the gender-affirming medical care ban for patients under 18 in Texas.

20. The implementation of laws like SB 14 only serves to erode the status of health equity in Texas. Our members and their patients thus stand to be negatively affected by SB 14 in several ways.

21. All individuals, including transgender and gender diverse youth, deserve access to respectful, compassionate, and evidence-based care. As outlined in our issue brief mentioned above, gender-affirming medical care improves the health, wellbeing, and quality of life of transgender people with gender dysphoria. Conversely, prohibiting access to this evidence-based and effective medical care leads to negative health outcomes. By prohibiting the provision of gender-affirming medical care to transgender adolescents and otherwise restricting access to this essential care such as by prohibiting Medicaid coverage, SB 14 puts transgender youth in Texas at risk of being denied lifesaving healthcare services, leading to potentially severe health consequences. Many of these youth are cared for by GLMA's members in Texas.

22. Laws like SB 14 are an affront to healthcare ethics and the principles of equality and inclusivity that should govern healthcare practices. Healthcare professionals have an ethical obligation to prioritize patient care and well-being, and laws like SB 14 undermine this obligation.

23. SB 14 prohibits the provision, prescription, administration, or dispensing of puberty-delaying medications and gender-affirming hormones to treat gender dysphoria, as well as the performing of gender-affirming surgery, including chest surgery. In doing so, SB 14 places GLMA's health professional members in an untenable position of choosing to comply with SB 14 and endanger the health and wellbeing of their transgender minor patients, or follow their medical or professional best judgment and duty to their patients and violate SB 14 by providing their adolescent patients with the best care and the care they need.

24. For physicians, SB 14 also mandates the revocation or denial of licensure to any physician who provides gender-affirming medical care to patients under 18, as well as additional disciplinary actions. It does so notwithstanding that gender-affirming medical care is evidence-based consistent with well-established clinical practice guidelines, and which is supported by the mainstream medical establishment in the United States.

25. GLMA, along with many of its sibling medical and health professional associations, such as the American Medical Association, American Psychiatric Association, American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatrists, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, Endocrine Society, Pediatric Endocrine Society, and others, supports the provision of gender-affirming medical care to treat gender dysphoria as evidence-based, safe, and effective medicine.

26. In addition, transgender patients frequently face heightened stigma and discrimination and are particularly apprehensive in medical encounters. These concerns of the

patients of GLMA's members are magnified by their well-founded belief that the Texas government is permitting, if not encouraging, discrimination by health care professionals and health care institutions.

27. One of the guiding ethics of medicine is to treat all patients equally. We do not treat blue-eyed people better than brown-eyed people. We do not treat women better than men. We do not provide better care to blonde-haired people than red-haired people. Health professionals see people at their most vulnerable; the trust placed in them is sacred. To tie a healthcare provider's hands, to not permit a provider to make individualized assessments of the medical needs of all patients, hurts patients by preventing them from accessing needed care even at trusted facilities and practices.

28. If GLMA's health professional members are to provide evidence-based care to their transgender minor patients that is consistent with their oaths, they cannot be forced to comply with SB 14. The Ban requires that GLMA's health professional members violate the dictates of their profession and medical ethics and denies care that is consistent with evidence-based and widely recognized clinical practice guidelines to our patients.

29. If not enjoined, SB 14 will harm GLMA's health professional members and the transgender young patients who GLMA's health professional members in Texas treat.

30. GLMA exists to foster a world where health care professionals can make decisions to best care for LGBTQ+ individuals. To prevent our members from being able to provide this oft lifesaving, evidence-based, and effective medical care would significantly hamper our mission to foster health equity for the LGBTQ+ community.

31. As an organization dedicated to supporting LGBTQ+ medical professionals and advocating for LGBTQ+ health equity, GLMA strongly condemns regressive measures like SB

14. GLMA vehemently opposes discriminatory bills like SB 14 and affirms our unwavering commitment to championing equitable and inclusive healthcare for all individuals, without exception.

32. GLMA stands united in its resolve to fight against such legislation that undermines the principles of equality, respect, and evidence-based care.

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

Executed on this 9th day of July 2023.

Alex Sheldon
Executive Director, GLMA

JURAT

State of North Carolina)
)
County of Mecklenburg)

Before me, a notary public, on this day personally appeared, Alex Sheldon, known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the foregoing instrument, and being first duly sworn by me states that the statements contained in the foregoing are true and correct to the best of his knowledge, information, and belief.

Sworn to and subscribed before me on the 9th day of July 2023, by Alex Sheldon.

IN TESTIMONY WHEREOF, I have set my hand and affixed my official seal on the day and year first written above.

ASHLEY BRISBON
Notary Public, North Carolina
Mecklenburg County
My Commission Expires
November 18, 2026

Notary Public

Exhibit 13

CAUSE NO.

LAZARO LOE, *et al.*,	§	
	§	
Plaintiffs,	§	
v.	§	IN THE DISTRICT COURT OF
	§	TRAVIS COUNTY, TEXAS
THE STATE OF TEXAS, *et al.*,	§	____ JUDICIAL DISTRICT
	§	
Defendants.	§	
	§	
	§	

AFFIDAVIT OF M. BRETT COOPER, M.D., M.Ed.

I, M. Brett Cooper, M.D., M.Ed., hereby declare and state as follows:

1. I am over 18 years of age, of sound mind, and in all respects competent to testify.

2. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and competently as to those facts.

3. I am a pediatrician and adolescent medicine doctor at Children's Medical Center Dallas in Dallas, Texas.

4. As part of my practice, I provide transgender adolescents with medical treatment for their gender dysphoria, including prescribing puberty-delaying medications and gender-affirming hormones.

5. I intend to continue providing gender-affirming medical care to transgender adolescents with gender dysphoria should the court stop Senate Bill 14 (hereafter "SB 14" or "the Ban") from taking effect and being enforced.

6. I am a member of GLMA: Health Professionals Advancing LGBTQ+ Equality, as well as of the American Academy of Pediatrics, American Medical Association, Society for Adolescent Health and Medicine, Texas Medical Association, and Texas Pediatric Society

7. I obtained my medical degree from Wright State University in 2011. I completed my residency in general pediatrics in 2015 at the University of Toledo/Toledo Children's Hospital and my fellowship in adolescent medicine in 2018 at Baylor College of Medicine/Texas Children's Hospital. Throughout medical school, as well as my residency and fellowship programs, I received training and obtained clinical experience in the provision of gender-affirming health care to gender-diverse youth.

8. I also hold a Master's of Education degree in curriculum and instruction for health care professionals from the University of Houston.

9. I am double board certified by the American Board of Pediatrics in General Pediatrics and Adolescent Medicine. I am licensed to practice medicine in the State of Texas.

10. In 2018, I became an Assistant Professor in the Department of Pediatrics at UT Southwestern Medical Center and an adolescent medicine provider at Children's Medical Center Dallas. This declaration reflects my personal opinions and beliefs, and is not made as a representative of UT Southwestern Medical Center or Children's Medical Center Dallas.

11. At Children's Medical Center Dallas, I specialize in adolescent and young adult medicine (ages 11–25). I maintain a panel of patients for whom I provide a wide spectrum of health care services, including, but not limited to gender-affirming medical care, including hormone treatment and puberty blockers; HIV treatment, testing, and prevention; and STD testing, treatment and prevention.

12. Over the course of my career, including my residency and fellowship, I have provided health care services and treatment to over 100 transgender young people and their families.

13. When providing gender-affirming medical care to transgender adolescents with gender dysphoria, I am informed by my training, clinical experience, as well as well-established clinical practice guidelines such as the *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, published by the World Professional Association for Transgender Health ("WPATH") in 2022, and *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, published by the Endocrine Society in 2017. I also utilize the diagnostic criteria for "Gender Dysphoria in Adolescents and Adults" set forth in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR), published by the American Psychiatric Association in 2013 and revised in 2022.

14. As with all other medical care I provide, care for gender dysphoria is individualized, based on the needs of the patient.

15. I do not provide any medical interventions to minor patients until after the onset of puberty.

16. If medical interventions are medically indicated for an adolescent with gender dysphoria, I provide puberty-delaying medications and gender-affirming hormones as appropriate to the patients. I provide this care consistent with evidence-based clinical practice guidelines such as the Endocrine Society Guidelines and WPATH Standards of Care, which include recommendations on when a patient may begin receiving care, dosages for treatment, and other recommendations.

17. Before providing gender-affirming medical interventions to my transgender patients, and consistent with clinical practice guidelines, we require a biopsychosocial assessment of the adolescent, which is typically conducted by a separate mental health provider.

18. For my transgender patients who are receiving hormone therapy, I monitor their bloodwork to assess hormone levels, lipid levels, blood count, and liver and kidney function. This type of monitoring helps ensure that patients are generally healthy and minimizes the risk of any adverse side effects from treatment, which are similar to when these medications are provided to my non-transgender patients.

19. The passage of Senate Bill 14 ("SB 14" or "the Ban") has caused a great deal of anxiety and fear amongst my patients and their families, as well as concern and distress amongst health care professionals like myself.

20. I understand that SB 14 requires the revocation of my medical license, as well as other disciplinary actions, if I were to provide gender-affirming medical care to a patient under 18 years of age after September 1, 2023 and who do not qualify under the "wean off" exception set forth in SB 14.

21. SB 14 thus not only endangers the health and wellbeing of my patients, but also places me in the unsustainable position of having to choose between providing my patients with the medical care that they need and deserve and having to comply with a discriminatory law like SB 14.

22. I have an ethical duty to provide my patients with the best medical care for their conditions, if it is medically indicated for them. I consider the provision of gender-affirming medical care to treat a transgender adolescent's gender dysphoria to be the best medical care for my patients when medically indicated.

23. The Society for Adolescent Health Medicine ("SAHM"), of which I am member, considers bills like SB 14 to be harmful to the health and wellbeing of transgender and gender diverse youth, a vulnerable population, and to have a negative impact and hinder the work of

clinicians who deliver gender-affirming care. As such, SAHM has adopted two position statements opposing such legislative restriction on the provision of gender-affirming medical care. *See* Society for Adolescent Health Medicine, *Statement on the Politicization of Gender-Affirming Care and Threats of Violence Against Clinicians* (2023), https://www.adolescenthealth.org/SAHM-News/SAHM-Statement-about-the-Politicization-of-Gender.aspx; Society for Adolescent Health Medicine, *SAHM Statement in Opposition of State Legislation Barring Evidence-Based Treatment* (2020), https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/SAHM-Opposition.aspx. These position statements further state, among other things, that there is growing robust evidence that these treatments are associated with better health outcomes for transgender and gender diverse youth; that legislative bans like SB 14 disproportionately impact transgender and gender diverse youth from minoritized backgrounds and communities of color who cannot travel or relocate for care; that laws like SB 14 may worsen preexisting health disparities by race, ethnicity, and socioeconomic status; and that laws like SB 14 limit the ability of clinicians to practice in accordance with evidence-based standards. I agree with each of these statements.

24. I also co-authored the Society for Adolescent Health Medicine's position statement "Recommendations for Promoting the Health and Well-being of Sexual and Gender-diverse Adolescents Through Supportive Families and Affirming Support Networks," published in the peer-reviewed *The Journal of Adolescent Health* in 2022. Among the recommendations contained in this paper is the recommendation that transgender and gender diverse youth in state systems, like foster care and juvenile justice systems, be provided access to gender-affirming care.

25. As a physician, whether a particular form of medical treatment should be provided should be based on discussions between the patient, the patient's parents/guardian if a minor, and myself, based on the patient's needs.

26. Notwithstanding that gender-affirming medical care has improved the health and wellbeing of many of my patients, I am now being prohibited from providing this safe and effective *treatment to adolescents with gender dysphoria, regardless of whether it is medically indicated for* them. SB 14 thus will interfere with my ability to provide the best care that I can to my patients.

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

Executed on this 8 day of July 2023.

Brett Cooper, MD
M. Brett Cooper, M.D., M.Ed.

JURAT

State of Texas)
)
County of Collin)

Before me, a notary public, on this day personally appeared, M. Brett Cooper, known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the foregoing instrument, and being first duly sworn by me states that the statements contained in the foregoing are true and correct to the best of his knowledge, information, and belief.

Sworn to and subscribed before me on the 8th day of July 2023, by M. Brett Cooper.

IN TESTIMONY WHEREOF, I have set my hand and affixed my official seal on the day and year first written above.

GLORIA COLLAZO
Notary ID #134104878
My Commission Expires
December 14, 2026

Gloria Collazo
Notary Public

Exhibit 14

CAUSE NO.

LAZARO LOE, et al., *Plaintiffs*, v. STATE OF TEXAS, et al., *Defendants*.	§ § § § § § § § § § §	IN THE DISTRICT COURT OF TRAVIS COUNTY, TEXAS ____ JUDICIAL DISTRICT

DECLARATION OF KATHRYN KOE, D.O.

I, Kathryn Koe, D.O.,[1] hereby declare and state as follows:

1. I am over 18 years of age, of sound mind, and in all respects competent to testify.

2. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and competently as to those facts.

3. I offer this declaration in support of Plaintiffs' Motion for a Temporary Injunction.

4. I am a pediatrician and adolescent medicine doctor living in Texas. Texas is my home. I grew up in Texas, received my undergraduate and medical education in Texas, did my residency in Texas, and have established a career in Texas.

5. I have provided transgender adolescents with medical treatment for their gender dysphoria, including prescribing puberty-delaying medications and gender-affirming hormones.

[1] Kathryn Koe is a pseudonym. I am aware of numerous instances in which providers of gender-affirming care like me have been doxxed—a form of relentless online harassment from having their private contact information shared publicly—and have had their lives threatened, including by people in Texas. Accordingly, I am submitting this declaration under a pseudonym to protect my privacy and protect my family and me from harassment and violence.

6. I intend to continue providing gender-affirming medical care to transgender adolescents with gender dysphoria should the court enjoin Senate Bill 14 (hereafter "SB 14" or "the Ban") from taking effect.

7. I am a member of GLMA: Health Professionals Advancing LGBTQ+ Equality, as well as of the American Academy of Pediatrics, the Society for Adolescent Health and Medicine, and the World Professional Association for Transgender Health ("WPATH").

8. I obtained my degree in osteopathic medicine eight years ago. I completed an internship and residency in pediatrics and a fellowship in adolescent medicine.

9. I am licensed to practice medicine in the State of Texas and am board certified in pediatrics.

10. I have also received training and obtained clinical experience in the provision of gender-affirming medical care to transgender youth.

11. As a pediatrician and adolescent medicine doctor, I treat a variety of conditions in my pediatric patients. This includes providing medical care to transgender adolescents with gender dysphoria.

12. I deliberately sought out training in providing care for transgender adolescents and established my medical practice to do so because I knew transgender people generally, and transgender youth in particular, are underserved populations.

13. Over the course of my career, including my residency and fellowship, I have provided health care services and treatment to over 50 transgender young people and their families.

14. Gender-affirming medical care for gender dysphoria is evidence-based care. In providing this care, I am informed by widely accepted clinical practice guidelines such as the *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, published

by WPATH in 2022; *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, published by the Endocrine Society in 2017; and the *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*, published by the Center of Excellence for Transgender Care at the University of California – San Francisco in 2016. I also utilize the diagnostic criteria for "Gender Dysphoria in Adolescents and Adults" set forth in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR), published by the American Psychiatric Association in 2013 and revised in 2022.

15. In my practice, before providing any medical care to an adolescent with gender dysphoria, we conduct a very thorough initial evaluation, which sometimes can take several visits and involves meeting with the adolescent patient and their guardians or parents, getting the perspective of the young person and the family. In doing so, I work with providers from other disciplines, such as mental health providers, to ensure we are properly assessing the patient and that the patient has the adequate support that they need.

16. After confirming that there is a diagnosis of gender dysphoria, we develop a treatment plan for the adolescent. Sometimes this involves assistance with social transition and sometimes involves medical treatment if medically indicated for the young person. Other times, we determine that medical treatment is not appropriate for the young person. The care provided to each patient is individualized, based on their particular needs and circumstances.

17. The aforementioned approach to treatment is consistent with evidence-based, widely accepted clinical practice guidelines, like the WPATH Standards of Care.

18. Depending on the patient's development including pubertal stage and maturity, the medical treatment may involve the provision of puberty-delaying medications or masculinizing or

feminizing hormones. I provide these same medical treatments to cisgender patients to treat other conditions. The risks and side effects of these treatments are similar when used to treat transgender and cisgender patients.

19. No medical interventions are provided to any patient prior to the onset of puberty.

20. The attacks on the provision of gender-affirming medical care over the past year in Texas have caused a great deal of confusion, anxiety, and distress to my transgender patients and their families. These attacks include not only the passage of SB 14 but also baseless investigations by the Texas Attorney General of institutions providing gender-affirming care, the exertion of political pressure to force the closure of clinics specializing in providing this care, and the Governor's directive attempting to treat the provision of this necessary and evidence-based care as child abuse.

21. I understand that SB 14 requires the revocation of my medical license and threatens other penalties if I were to provide gender-affirming medical care to a patient under 18 years of age after September 1, 2023. This is an untenable position for me. Do I comply with this discriminatory law or do what I think is medically indicated and ethically and morally correct?

22. I have a duty to provide my patients with the best medical care for them, based on their needs and circumstances. SB 14 prevents me from doing that, bars me from treating my patients with gender dysphoria according to the generally accepted standards of care, interferes with my ability to practice medicine and the doctor-patient relationship, and endangers the health and well-being of my patients.

23. As a health care provider, whether a particular form of medical treatment is provided should be based on discussions between the patient, the patient's parents/guardian if a minor, and the doctor, and the patient's needs.

24. I have seen how gender-affirming medical care has improved my patients' lives, health, and well-being. I have seen lives forever changed for the better when their gender dysphoria is actually addressed through puberty-delaying medications and/or gender-affirming hormones, and they are affirmed for who they are.

25. I believe SB 14 will interfere with my ability to provide the best care that I can for my patients—care that, in my opinion, is evidence-based, necessary, and often lifesaving. SB 14 is thus a barrier to me saving a life.

26. The passage of SB 14 has made difficult circumstances feel even more precarious for my patients and their families. I believe SB 14 has put them in a position where it is no longer their choice to stay in Texas, where they call home. While I have been able to assist some of my patients with establishing care outside of Texas, many others do not have the resources or ability to obtain care elsewhere, whether by relocating and seeking refuge outside Texas or by repeatedly traveling to states that do not bar access to medically necessary care.

27. For my patients and their families who have the resources and ability to relocate, moving away from Texas will likely mean taking them away from their biggest support systems--their friends, the people in their community who support them--and forcing them to essentially start over somewhere new, hoping to find a safe haven there.

28. I believe that most of my patients and their families do not have the resources or ability to leave and relocate outside Texas. They do not have the finances to uproot their lives. They do not have the connections to uproot their lives. So now families must live in fear and wonder if they are ever going to get the care that their transgender adolescents deserve and need. I understand that close to one-third of my patients are on Medicaid or CHIP and so SB 14 doubly

impacts them as it prohibits coverage of this evidence-based, necessary care, even if medically indicated, which they cannot afford otherwise.

29. SB 14 and Texas's repeated attacks on gender-affirming medical care have made it more difficult for providers like me to continue our medical practices and provide our patients with the medical care that they need. Still, I intend to continue providing this care when medically indicated for my patients should the Court prevent SB 14 from taking effect or being enforced.

30. I have seen transgender youth who have wanted to commit suicide and engage in life-threatening risky behaviors due to, in large part, the incredible distress they experience as a result of their gender dysphoria grow up and graduate high school and live full lives because they had access to medical care for their gender dysphoria. That is what I call good medicine. That is just good care. If I can help one individual do that, I will continue providing gender-affirming medical care if SB 14 is stopped from taking effect and being enforced.

31. My name is [redacted]. My date of birth is [redacted]. My address is [redacted]. I declare under penalty of perjury that the foregoing is true and correct.

Executed in Travis County, Texas on this 10th day of July 2023.

Kathryn Koe, D.O.

[redacted]

Exhibit 15

CAUSE NO.

LAZARO LOE, *et al.*, *Plaintiffs*, v. THE STATE OF TEXAS, *et al.*, *Defendants*.	§	IN THE DISTRICT COURT OF TRAVIS COUNTY, TEXAS ____ JUDICIAL DISTRICT

EXPERT AFFIDAVIT OF DANIEL SHUMER, M.D.

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

1. I am over 18 years of age, of sound mind, and in all respects competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. The opinions expressed herein are my own and do not express the views or opinions of my employer.

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

I. BACKGROUND AND QUALIFICATIONS

A. Qualifications

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

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

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

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

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

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

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

11. As a Fellow at Harvard, I was mentored by Dr. Norman Spack. Dr. Spack established the Gender Management Services Clinic (GeMS) at Boston Children's Hospital. While

working and training at GeMS, I became a clinical expert in the field of transgender medicine within Pediatric Endocrinology and began conducting research on gender identity, gender dysphoria, and the evaluation and management of gender dysphoria in children and adolescents.

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

13. The Child and Adolescent Gender Services Clinic has treated over 600 patients since its founding. The clinic provides comprehensive assessment, and when appropriate, treatment with pubertal suppression and hormonal therapies, to patients diagnosed with gender dysphoria. I have personally evaluated and treated over 400 patients with gender dysphoria. The majority of the patients receiving care range between 10 and 21 years old. Most patients attending clinic live in Michigan or Ohio. As the Clinical Director, I oversee the clinical practice, which currently includes 5 physicians (including 1 psychiatrist), 1 nurse practitioner, 2 social workers, 1 research coordinator, as well as nursing and administrative staff. I also actively conduct research related to transgender medicine, gender dysphoria treatment, and mental health concerns specific to transgender youth.

14. I also provide care in in the Differences/Disorders of Sex Development (DSD) Clinic at Michigan Medicine at Mott Children's Hospital. The DSD Clinic is a multidisciplinary clinic focused on providing care to infants and children with differences in the typical path of sex development, which may be influence by the arrangement of sex chromosomes, the functioning of our gonads (i.e. testes, ovaries), and our bodies' response to hormones. The clinic is comprised of

members from Pediatric Endocrinology, Genetics, Psychology, Urology, Gynecology, Surgery, and Social Work. In this clinic I have assessed and treated over 100 patients with DSD.

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

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

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

B. Prior Testimony

18. In the past four years, I have been retained as an expert and provided testimony at trial or by deposition in the following cases: *Dekker v. Weida*, No. 4:22-cv-00325 (N.D. Fla.); *K.C. v. The Individual Members of the Medical Licensing Board of Indiana*, No. 1:23-cv-00595 (S.D. Ind.); *Boe v. Marshall*, No. 2:22-cv-184 (M.D. Ala.); *Roe et al v. Utah High School Activities*

Association et al (Third District Court in and for Salt Lake County, UT); *Menefee v. City of Huntsville Bd. of Educ.*, No. 5:18-cv-01481 (N.D. Ala.); and *Cooper v. USA Powerlifting and Powerlifting Minnesota*, No. 62-CV-21-211 (Ramsey Cnty. Dist. Ct., Minn.). I also provided expert witness testimony on behalf of a parent in a custody dispute involving a transgender child in the following case: *In the Interest of Younger*, No. DF-15-09887 (Dallas County, Texas).

C. Compensation

19. I am being compensated at an hourly rate for the actual time that I devote to this case, at the rate of $350 per hour for any review of records, preparation of reports, declarations, and deposition and trial testimony. My compensation does not depend on the outcome of this litigation, the opinions that I express, or the testimony that I provide.

D. Bases for Opinions

20. This report sets forth my opinions in this case and the bases for my opinions.

21. In preparing this report, I reviewed the text of Senate Bill 14 (hereafter, "SB 14", "the Act", or "the Ban"), enacted by the 88th Texas legislature and signed into law by Governor on June 2, 2023, as well as the House Research Organization bill analysis of SB 14, dated May 12, 2023.

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

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

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

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

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

II. EXPERT OPINIONS

A. MEDICAL AND SCIENTIFIC BACKGROUND ON SEX AND GENDER IDENTITY

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

28. *Gender identity* is the medical term for a person's internal, innate sense of belonging to a particular sex. Everyone has a gender identity. Diversity of gender identity and incongruence between assigned sex at birth and gender identity are naturally occurring and part of human biological diversity (IOM, 2011). The term *transgender* refers to individuals whose gender identity does not align with their sex assigned at birth (Shumer, et al., 2013).

29. *Gender identity* does not refer to socially contingent behaviors, attitudes, or personality traits. It is an internal and largely biological phenomenon.

30. Living consistent with one's gender identity is critical to the health and well-being of any person, including transgender people (Hidalgo, et al., 2013; Shumer, et al., 2013; White Hughto, et al., 2015).

31. A person's understanding of their gender identity may evolve over time in the natural course of their life, however, attempts to force transgender people to align their gender identity with their birth sex (sometimes decried as "conversion therapy") have been found to be both harmful and ineffective. In one study, transgender adults who recall previous attempts from healthcare professionals to alter their gender identity reported an increase in lifetime suicide attempts and higher rates of severe psychological distress in the present (Turban, et al., 2020a). In another study, exposure to these types of attempts were found to increase the likelihood that a transgender adolescent will attempt suicide by 55% and more than double the risk for running away from home (Campbell, et al., 2002). Those practices have been denounced as unethical by all major professional associations of medical and mental health professionals, such as the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, and the American Psychological Association, among others (Fish, et al., 2022).

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

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

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

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

36. The above studies are representative examples of scientific research demonstrating biological influences on gender identity. Gender identity, like other complex human

characteristics, is rooted in biology with important contributions from neuroanatomic, genetic and hormonal variation (Roselli, 2018).

B. ASSESSMENT OF GENDER DYSPHORIA IN CHILDREN AND ADOLESCENTS

37. Due to the incongruence between their assigned sex and gender identity, transgender people experience varying degrees of gender dysphoria, a serious medical condition defined in both the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR) (APA, 2022).

38. *Gender Dysphoria* is defined as an incongruence between a patient's assigned sex and their gender identity present for at least six months, which causes clinically important distress in the person's life. This distress is further defined as impairment in social, occupational, or other important areas of functioning (APA, 2022). Additional features may include a strong desire to be rid of one's primary or secondary sex characteristics, a strong desire to be treated as a member of the identified gender, or a strong conviction that one has the typical feelings of identified gender (APA, 2022).

39. The *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8* ("SOC 8"), published by the World Professional Association for Transgender Health (WPATH), provides guidance to providers on how to provide comprehensive assessment and care to this patient population based on medical evidence. These standards recommend involving relevant disciplines, including mental health and medical professionals, to reach a decision with families about whether medical interventions are appropriate and remain indicated through the course of treatment.

40. In children and adolescents, a comprehensive biopsychosocial assessment is typically the first step in evaluation, performed by a mental health provider with experience in

gender identity. The goals of this assessment are to develop a deep understanding of the young person's experience with gender identity, to consider whether the child or adolescent meets criteria for a diagnosis of gender dysphoria, and to understand what options may be desired and helpful for the adolescent (Coleman, et al., 2022; Coleman, et al., 2012; Hembree, et al., 2017; Hembree, et al., 2009).

41. In children and adolescents, the diagnosis of gender dysphoria is made by a mental health provider including but not limited to a psychiatrist, psychologist, social worker, or therapist with expertise in gender identity concerns. It is recommended that children and adolescents diagnosed with gender dysphoria engage with a multidisciplinary team of mental health and medical professionals to formulate a treatment plan, in coordination with the parent(s) or guardian(s), with a goal of reduction of gender dysphoria.

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

43. For transgender adolescents, all treatment decisions are made in consultation with the adolescent and the adolescent's parent or guardian with the parent or guardian providing ultimate consent for treatment.

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

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

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

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

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

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

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

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

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

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

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

53. In addition, the Endocrine Society is a 100-year-old global membership organization representing professionals in the field of adult and pediatric endocrinology. In 2017, the Endocrine Society published clinical practice guidelines on treatment recommendations for the medical management of gender dysphoria, in collaboration with Pediatric Endocrine Society, the European Societies for Endocrinology and Pediatric Endocrinology, and WPATH, among others (Hembree, et al, 2017).

54. The Endocrine Society Clinical Guidelines were developed through rigorous scientific processes that "followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines." The guidelines

affirm that patients with gender dysphoria often must be treated with "a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender." (Hembree, et al., 2017).

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

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

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

D. TREATMENT PROTOCOLS FOR GENDER DYSPHORIA

58. Undergoing treatment to alleviate gender dysphoria is commonly referred to as a transition. The transition process in adolescence typically includes (i) social transition and/or (ii)

medications, including puberty-delaying medication and hormone therapy. The steps that make up a person's transition and their sequence will depend on that individual's medical and mental health needs and decisions made between the patient, family, and multidisciplinary care team.

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

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

61. After the onset of puberty, puberty-delaying medication and hormone-replacement therapy—both individually and in combination—can significantly improve the mental health of adolescents diagnosed with gender dysphoria. These treatments allow for a patient's physiological characteristics to more closely align with gender identity and decreases the likelihood that the

young person will be incorrectly identified with their assigned sex, further alleviating their gender dysphoria.

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

i. Treatment with puberty-delaying medications

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

64. The treatment works by pausing endogenous puberty at whatever stage it is at when the treatment begins, limiting the influence of a person's endogenous hormones on their body. For example, a transgender girl will experience no progression of physical changes caused by testosterone, including facial and body hair, an Adam's apple, or masculinized facial structures. And, in a transgender boy, those medications would prevent progression of breast development,

menstruation, and widening of the hips (Coleman, et al., 2022; de Vries, et al., 2012; Deutsch (ed.), 2016; Hembree, et al., 2017; Rosenthal, 2014).

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

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

67. Prior to initiation of GnRHa, providers counsel patients and their families extensively on potential benefits and risks. Designed benefit of treatment is to reduce the risk of worsening gender dysphoria and mental health deterioration. More specifically, use of GnRHa in transmasculine adolescents allows for decreased chest development, reducing the need for breast binding and surgical intervention in adulthood. For transfeminine adolescents GnRHa limits facial and body hair growth, voice deepening, and masculine bone structure development, which greatly reduce distress both at the time of treatment and later in life and reduce the need for later interventions such as voice therapy, hair removal, and facial feminization surgery.

68. The goal in using GnRHa is to minimize the patient's dysphoria related to progression of puberty and allow for later initiation of puberty consistent with gender identity. When a patient presents to care, the provider assesses the patient's pubertal stage, pubertal history,

and individual needs. A patient may present prior to the onset of puberty (Tanner Stage 1), at the onset of puberty (Tanner Stage 2), or further along in puberty (Tanner Stages 3-5). The pubertal stage and individual needs of the patient then direct conversations regarding care options. A patient at Tanner Stage 2 may benefit from GnRHa, while an older patient who has completed puberty may benefit from pubertal initiation with hormones, as described below. I have observed that providing individualized care based on individual patient characteristics, using the WPATH Standards of Care as the foundation of this care, provides significant benefit to patients, minimizes gender dysphoria, and can eliminate the need for surgical treatments in adulthood.

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

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

ii. Treatment with hormone therapy

71. In mid-adolescence, the patient, their parents, and the patient's care team may discuss the possibility of beginning the use of testosterone or estrogen. In my practice we discuss these treatments for a patient who is currently receiving GnRHa, or patients who have already gone through their endogenous puberty and either did not have access to, desire, or elect for GnRHa treatment. In adult patients, use of GnRHa is uncommon, but rather medical decisions are focused more on testosterone or estrogen therapy.

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

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

74. Under the Endocrine Society Clinical Guidelines and SOC 8, hormone therapy is an appropriate treatment for transgender adults with gender dysphoria when the experience of dysphoria is marked and sustained, other possible causes of apparent gender dysphoria are

excluded, any mental and physical health conditions that could negatively impact the outcome of treatment are assessed, the adult has capacity to understand risks and benefits of treatment and provide consent for treatment (Coleman, et al., 2022; Hembree, et al., 2017).

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

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

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

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

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

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

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

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

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

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

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

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

85. Hormone therapy (testosterone or estrogen) is prescribed to older adolescents with gender dysphoria. As is the case with GnRHa, the need for hormone therapy is not unique to transgender adolescents. Patients with conditions such as delayed puberty, hypogonadism, Turner Syndrome, Klinefelter Syndrome, agonism, premature ovarian failure, and disorders of sex development all require treatment with these hormones, often times starting in adolescence and continuing lifelong. Without testosterone or estrogen treatment, these patients would be unable to progress through puberty normally, which would have serious medical and social consequences. Whether used in adolescents to treat gender dysphoria, or to treat any of these other conditions, testosterone and estrogen are prescribed with a goal to raise the testosterone or estrogen level into the normal male or female range for the patient's age. Careful monitoring of blood levels and clinical progress are required. Side effects are rare, but most often related to overtreatment, which can be minimized with this monitoring. Additionally, side effects are considered, discussed, and easily managed in all individuals needing hormone therapy regardless of the diagnosis necessitating these medications.

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

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

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

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

89. The efficacy of hormone treatment in transgender adults is similarly robust. At least 11 longitudinal studies document improvement in various mental health parameters including depression, anxiety, self-confidence, body image and self-image, general psychological functioning (e.g., Colizzi, et al., 2013; Colizzi, et al., 2014; Corda, et al., 2016; Defreyne, et al., 2018; Fisher, et al., 2016; Heylens, et al., 2014; Keo-Meier, et al., 2015; Manieri, et al., 2014; Motta, et al., 2018; Oda, et al., 2017; Turan, et al., 2018).

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

F. Specific Observations and Criticisms for Justifications for the SB 14

91. SB 14 is a threat to the health and wellness of transgender adolescents in Texas. The justifications for this Ban, which are outlined in the House Research Organization's bill analysis dated May 12, 2023, are not well founded as they are primarily based on misinformation, misrepresentation of scientific literature, or a lack of understanding.

92. For example, per the bill analysis, one of the justifications for the SB 14 is that "[c]hildren and adolescents are not able to give fully informed consent for such serious treatment." However, this demonstrates a lack of understanding of how medical care is provided to adolescents with gender dysphoria. Informed consent is essential in medicine. Medical providers become skilled in explaining risks and benefits of interventions so each patient can make the best medical decision for their situation. In the context of medical care for adolescents, it is the parents or legal guardians of the minor patient who provide consent while the patient provides assent. As noted above, the WPATH Standards of Care recommend that prior to the initiation of any medical intervention a provider determine whether the adolescent "demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment" (Coleman, et al., 2022).

93. Supporters of the Ban also argue that "in many cases adolescent gender dysphoria resolves itself over time." Presumably, in making such an argument, supporters refer (incorrectly) to the notion of desistance. This fallacy, repeated by many opponents of gender-affirming medical care, misrepresents the data completely. While it is true that the majority of prepubertal gender diverse children exploring their gender do not develop gender dysphoria and are not expected to become transgender adolescents or adults, that is because those children are not transgender in the first place. First, as noted above (paragraph 60), the studies included gay children and gender nonconforming children who were never transgender. Second, because prepubertal children are

not treated with hormonal medications for gender dysphoria, studies that look at prepubertal children have no relevance to the question of how to treat adolescents. Children whose gender dysphoria persists into adolescence are highly likely to be transgender (van der Loos, et al., 2022).

94. According to the bill analysis, supporters of the Act also assert that "[t]here is not conclusive evidence to suggest that treatments aimed at physical transition are effective in resolving dysphoria." This is false. As I have explained in this declaration (e.g., paragraphs 83 and 87), there are numerous studies documenting the benefits of GnRHa and hormones as treatment for gender dysphoria on both short-term and long-term psychological functioning and quality of life of transgender adolescents.

95. The House Research Organization's bill analysis further notes that the Act's supporters argue that "[p]rofessional counseling remains the best and most scientifically supported treatment for minors with gender dysphoria." This assertion is without any foundation. There is simply no evidence that psychotherapy alone is sufficient to resolve adolescent patient's gender dysphoria particularly when medical interventions are medically indicated for such patient.

96. Finally, SB 14's supporters have argued that "[r]egulatory authorities in several European nations where gender-related healthcare is long established have begun to reverse support for hormonal gender-related treatment for minors based on a lack of supporting evidence in systematic reviews." Presumably, this is in reference to limited restrictions in *how* gender-affirming medical care is provided to adolescents with gender dysphoria in a small handful of countries (like Finland and Sweden). However, gender-affirming medical care as treatment for gender dysphoria is still available in the countries mentioned.

III. CONCLUSION

97. In summary, banning gender-affirming medical care for adolescents regardless of individual patient need runs counter to evidence-based best practices and standards of care for the treatment of gender dysphoria.

98. Prohibiting gender-affirming medical care, and coverage thereof, for adolescents with gender dysphoria in Texas is likely to have devastating consequences and will result in worse outcomes for countless young persons in Texas. I am concerned that SB 14 might lead to a staggering increase in mental health problems including suicidality for adolescents with gender dysphoria in Texas.

99. In my own clinical practice in Michigan, I have seen an influx of patients from states banning medically proven treatments for gender dysphoria who report not feeling safe living in the community that they have always called home. These patients unfortunately often have to wait long periods of time to resume care and when they are seen, the impact of this delay is devastating on their mental health. They have described themselves as "refugees" in their own country, moving to avoid discriminatory laws which they know would clearly harm their health or the health of their child.

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

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

Executed this 10th day of July 2023.

Daniel Shumer, M.D.

JURAT

State of Michigan)
)
County of Washtenaw)

Before me, a notary public, on this day personally appeared, Daniel Shumer, M.D., known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the foregoing instrument, and being first duly sworn by me states that the statements contained in the foregoing are true and correct to the best of his knowledge, information, and belief.

Sworn to and subscribed before me on the 10th day of July 2023, by Daniel Shumer, M.D.

IN TESTIMONY WHEREOF, I have set my hand and affixed my official seal on the day and year first written above.

Notary Public

HILLERY D KEEFER
NOTARY PUBLIC - STATE OF MICHIGAN
County of Washtenaw
My Commission Expires 7/9/2025
Acting in the County of Washtenaw

EXHIBIT A

Curriculum vitae

Daniel Shumer, MD MPH

Clinical Associate Professor in Pediatrics - Endocrinology

Email: dshumer@umich.edu

EDUCATION AND TRAINING

Education

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

Postdoctoral Training

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

CERTIFICATION AND LICENSURE

Certification

10/2011-Present	American Board of Pediatrics, General

Licensure

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

09/2015-Present Michigan, DEA Registration

09/2015-Present Michigan, Controlled Substance

WORK EXPERIENCE

Academic Appointment

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

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

Administrative Appointment

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

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

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

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

Clinical Appointments

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

Private Practice

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

RESEARCH INTERESTS

- Gender dysphoria
- Prader Willi Syndrome

CLINICAL INTERESTS

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

GRANTS

Past Grants

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

HONORS AND AWARDS

National

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

Institutional

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

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

TEACHING MENTORSHIP

Resident

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

Clinical Fellow

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

Medical Student

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

TEACHING ACTIVITY

Regional

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

Institutional

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

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

MEMBERSHIPS IN PROFESSIONAL SOCIETIES

2012 - Present	Pediatric Endocrine Society

COMMITTEE SERVICE

National

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

Regional

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

Institutional

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

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

VOLUNTEER SERVICE

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

SCHOLARLY ACTIVITIES

PRESENTATIONS

Extramural Invited Presentation Speaker

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

Other

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PUBLICATIONS/SCHOLARSHIP

Peer-Reviewed Articles

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

Chapters

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

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

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

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

Non-Peer Reviewed Articles

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

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

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

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

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

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

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

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Exhibit 16

CAUSE NO.

LAZARO LOE, *et al.*,	§	
	§	
Plaintiffs,	§	
v.	§	IN THE DISTRICT COURT OF
	§	TRAVIS COUNTY, TEXAS
THE STATE OF TEXAS, *et al.*,	§	____ JUDICIAL DISTRICT
	§	
Defendants.	§	
	§	
	§	

EXPERT AFFIDAVIT OF ARON JANSSEN, M.D.

I, Aron Janssen, M.D., hereby declare and state as follows:

1. I am over 18 years of age, of sound mind, and in all respects competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. The opinions expressed herein are my own and do not express the views or opinions of my employer.

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

BACKGROUND AND QUALIFICATIONS

A. Qualifications

4. I am the Vice Chair of the Pritzker Department of Psychiatry and Behavioral Health at the Ann and Robert H. Lurie Children's Hospital of Chicago ("Children's Hospital"), where I also serve as Clinical Associate Professor of Child and Adolescent Psychiatry. I maintain a clinical practice in Illinois where I treat patients from Illinois and the surrounding states.

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

6. In 2011, I founded the Gender and Sexuality Service at New York University, for which I served as Clinical Director. I also previously served as Co-Director of the New York University Pediatric Consultation Liaison Service for the New York University Department of Child and Adolescent Psychiatry.

7. I am board certified in Child and Adolescent Psychiatry and Adult Psychiatry.

8. I have been treating children and adolescents with gender dysphoria for over 12 years. I have seen and treated over 500 children and adolescents with gender dysphoria during my medical career. Currently, approximately 90 percent of the patients in my clinical practice are transgender children and adolescents.

9. As part of my practice, I stay current on medical research and literature relating to the care of transgender persons and patients with gender dysphoria. I am an Associate Editor of the peer-reviewed publication *Transgender Health* and a reviewer for *LGBT Health* and *Journal of the American Academy of Child and Adolescent Psychiatry*, both of which are peer-reviewed journals.

10. I am the author or co-author of 16 peer-reviewed articles on care for transgender patients and am the co-editor of *Affirmative Mental Health Care for Transgender and Gender Diverse Youth: A Clinical Casebook* (Springer Publishing, 2018), which is the first published clinical casebook on the mental health treatment for children and adolescents with gender dysphoria. I have also authored or co-authored numerous book chapters on treatment for transgender adults and youth.

11. I have been a member of the World Professional Association for Transgender Health ("WPATH") since 2011. I was actively involved in the revision of WPATH's *Standards of Care for the Health of Transgender and Gender Diverse People* ("Standards of Care"), serving as

a member of revision committees for both the child and adult mental health chapters of version 8 of WPATH's Standards of Care (SOC 8), published in 2022.

12. In addition to the above, I am involved in training other medical and mental health providers in the treatment of children and adolescents with gender dysphoria. I have conducted trainings for over 1,000 medical and mental health providers and have given dozens of public addresses, seminars, and lectures on the treatment of gender dysphoria in children and adolescents.

13. I am also involved in a number of international, national, and regional committees that contribute to the scholarship and provision of care to transgender people. I am the Chair of the American Academy of Child and Adolescent Psychiatry's Sexual Orientation and Gender Identity Committee. I serve as a member of the Transgender Health Committee for the Association of Gay and Lesbian Psychiatrists. I am the Founder and former Director of the Gender Variant Youth and Family Network.

14. Further information about my professional background and experience is outlined in my curriculum vitae, a true and accurate copy of which is attached as **Exhibit A** to this declaration.

B. Prior Testimony

15. Within the last four years, I testified as an expert at trial or by deposition in: *Dekker v. Weida*, No. 4:22-cv-00325 (N.D. Fla.); *B.P.J. v. W. Va. Bd. of Educ.*, Case No. 2:21-cv-00316 (S.D. W.Va.); and *L.E. v. Lee*, Case No. 3:21-CV-00835 (M.D. Tenn.).

C. Compensation

16. I am being compensated for my work on this matter at a rate of $400 per hour for preparation of this declaration and for time spent preparing for and giving local deposition or trial testimony. In addition, I would be compensated $2,500 per day for deposition or trial testimony requiring travel and $300 per hour for time spent travelling, plus reasonable expenses. My

compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

D. Bases for Opinions

17. My opinions contained in this declaration are based on: (1) my clinical experience as a psychiatrist treating patients with gender dysphoria, including transgender children, adolescents, and young adults; (2) my knowledge of the peer-reviewed research, including my own, regarding the treatment of gender dysphoria, which reflects advancements in the field of transgender health; (3) my knowledge of the clinical practice guidelines for the treatment of gender dysphoria, including my work as a contributing author of WPATH SOC 8; and (4) my review of any of the materials cited herein.

18. In preparing this declaration, I reviewed the text of Senate Bill 14 (hereafter, "SB 14", "the Act", or "the Ban"), enacted by the 88th Texas legislature and signed into law by Governor on June 2, 2023, as well as the House Research Organization bill analysis of SB 14, dated May 12, 2023.

19. I have relied on my years of research and clinical experience in child, adolescent, and adult psychiatry, as well as my professional knowledge, as set out in **Exhibit A** and the materials listed therein.

20. In addition, I have also reviewed the materials listed in the bibliography attached as **Exhibit B**. I may rely on those documents as additional support for my opinions.

21. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

22. To my knowledge, I have not met or spoken with any of the Plaintiffs in this case.

SUMMARY OF OPINIONS

23. Gender-affirming medical care for transgender adolescents—including puberty-delaying medication and gender-affirming hormones—is widely accepted as medically necessary treatment for gender dysphoria.

24. The following medical groups, among others, recognize that gender-affirming medical care is safe and effective: American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the American Psychological Association, the American Psychiatric Association, and the American Medical Association, among many other mainstream medical organizations.

25. Under the World Professional Association for Transgender Health ("WPATH") Standards of Care and treatment guidelines from the Endocrine Society, gender-affirming medical treatment is provided only after a careful and thorough assessment of a patient's mental health, including co-occurring conditions, history of trauma, and substance use, among many other factors.

26. There is robust evidence demonstrating the value of medical interventions for adolescents when in the context of an appropriate psychosocial evaluation.

27. Studies have repeatedly documented that puberty-delaying medication and gender-affirming hormone therapy are associated with mental health benefits in both the short and long term. Further, I have seen first-hand countless times the benefits that adolescents can have when they have access to this safe and necessary medical care.

28. By contrast, there is no evidence that adolescents with persistent gender dysphoria can be treated with mental health therapy to stop being transgender, and such practices have been

shown to be harmful and unethical. Banning transgender youth from receiving gender-affirming care will profoundly harm the mental health and wellbeing of people who need it.

EXPERT OPINIONS

A. Gender Identity

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

30. Gender identity is a person's core sense of belonging to a particular gender, such as male or female.

31. Gender identity is one of a person's multiple sex characteristics, which also include, among others, internal reproductive organs, external genitalia, chromosomes, hormones, and secondary sex characteristics.

32. Living in a manner consistent with one's gender identity is critical to the health and wellbeing of any person, including transgender people.

33. Every person has a gender identity. It is not a personal decision, preference, or belief. A transgender boy cannot simply turn off his gender identity like a switch, any more than a non-transgender boy or anyone else could.[1]

[1] Some older studies have shown that prepubertal children with gender non-conforming expression realize with the onset of puberty that their gender identity is consistent with their sex assigned at birth. Those studies are subject to criticism for not accurately measuring "desistance" of a transgender identity among children. But even if those studies of prepubertal children were accepted uncritically, there are no studies that claim to document similar "desistance" once a minor reaches adolescence. *See* Madeleine S.C. Wallien, Peggy T. Cohen-Kettenis, *Psychosexual Outcome of Gender-Dysphoric Children*, JOURNAL OF THE AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY, Volume 47, Issue 12, 2008, Pages 1413-1423, ISSN 890-8567, https://doi.org/10.1097/CHI.0b013e31818956b9.

34. Current science recognizes that gender identity is innate and strongly indicates that gender identity has a biological basis.

35. The evidence demonstrating that gender identity cannot be altered, either for transgender or for non-transgender people, further underscores the innate nature and immutable of gender identity. Past attempts to "cure" transgender persons by using talk therapy, and even aversive therapy, to change their gender identity to match their birth-assigned sex were ineffective and caused extreme psychological damage.[2] That conclusion is further bolstered by the extensive evidence that rejection of a young person's gender identity from family and peers are the strongest predictors for adverse mental health outcomes.

36. Every leading medical and mental health organization has issued clear statements that those practices are discredited, harmful, and ineffective. This includes the American Medical Association (2017), the American Psychiatric Association (2018), the American Academy of Child & Adolescent Psychiatry (2018), the American Psychological Association (2021), and the American Academy of Pediatrics (Rafferty, et al., 2018), among others.

37. There is no one way by which people experience their gender identity development from early questioning to consolidation and affirmation. Though it is common for transgender youth to come out at puberty, for other transgender persons this is not true, and it may take them longer to come to recognize and acknowledge their gender identity. For the latter group, this is not due to some "late onset" of dysphoric feelings or sudden understanding themselves as

[2] Turban, et al., *Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults*, 77 JAMA PSYCHIATRY 68 (2020); Green, A. E., Price-Feeney, M., Dorison, S. H., & Pick, C.J. (2020). *Self-reported conversion efforts and suicidality among US LGBTQ youths and young adults, 2018*. AMERICAN JOURNAL OF PUBLIC HEALTH, 110(8), 1221–1227; Craig, S. L., Austin, A., Rashidi, M., & Adams, M. (2017). *Fighting for survival: The experiences of lesbian, gay, bisexual, transgender, and questioning students in religious colleges and universities*. JOURNAL OF GAY & LESBIAN SOCIAL SERVICES*, 29*(1), 1–24.

transgender, it is the result of a long and difficult process toward accepting and understanding themselves in a social context where being transgender is still a difficult reality due to external stigma, fears of family and social rejection, and even internalized transphobia (Pullen Sansfaçon, et al., 2020).

B. Gender Dysphoria and Its Diagnostic Criteria

38. The term "gender dysphoria" is the distress related to the incongruence between one's gender identity and one's sex assigned at birth.

39. Gender Dysphoria (capitalized) is the clinical diagnosis for the significant distress that results from the incongruity between one's gender identity and sex assigned at birth. It is a serious medical condition, and it is codified in the American Psychiatric Association's in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR) (DSM-5 released in 2013 and DSM-5-TR released in 2022).

40. The DSM-5 defines gender dysphoria as a: "marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. In children, the desire to be of the other gender must be present and verbalized. This condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning."

41. The DSM-5 also states that: "gender dysphoria is manifested in a variety of ways, including strong desires to be treated as the other gender or to be rid of one's sex characteristics, or a strong conviction that one has feelings and reactions typical of the other gender."

42. "Gender Dysphoria in Children" is a diagnosis applied only to prepubertal children in the DSM-5. The DSM-5 has a separate diagnosis of "Gender Dysphoria in Adolescents and Adults." The diagnostic criteria for these diagnoses are distinct.

43. Understanding that children have less capacity to articulate abstract concepts about the sense of self as well as a reflection of what can be a lack of specificity of gender nonconforming behaviors in childhood, there are more nuanced criteria to make the diagnosis for children.

44. The criteria for the diagnosis of "Gender Dysphoria in Children" are:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or insistence that one is the other gender (or some alternative gender different from one's assigned gender)

2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.

3. A strong preference for cross-gender roles in make-believe play or fantasy play.

4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.

5. A strong preference for playmates of the other gender.

6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.

7. A strong dislike of one's sexual anatomy.

8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social circles, school, or other important areas of functioning.

45. By contrast, the criteria for the separate DSM-5 diagnosis of "Gender Dysphoria in Adolescents and Adults" are:

A. A marked incongruence between experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).

2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

46. Simply being transgender or gender nonconforming is not a medical condition or pathology to be treated. As the DSM-5 recognizes, diagnosis and treatment are "focus[ed] on dysphoria as the clinical problem, not identity per se." (DSM-5, at 451). The DSM-5 unequivocally repudiated the outdated view that being transgender is a pathology by revising the diagnostic criteria (and name) of gender dysphoria to recognize the clinical distress as the focus of the treatment, not the patient's transgender status.

47. When untreated, gender dysphoria can cause significant distress including increased risk of depression, anxiety, and suicidality. This is noted both in adolescents and adults. However, these risks decline when transgender people are supported and live according to their gender identity. Not only is this documented in scientific literature and published data, but I

witness this each time I see my patients being supported by their community, family, school, and medical providers.

C. Evidence-Based Guidelines for the Treatment of Gender Dysphoria

48. The World Professional Association of Transgender Health ("WPATH") has issued Standards of Care for the Health of Transgender and Gender Diverse People ("WPATH Standards of Care") since 1979. The current version is SOC 8, published in 2022. The WPATH Standards of Care, which are widely accepted in the medical community, provide guidelines for multidisciplinary care of transgender individuals, including children and adolescents, and describes criteria for medical interventions to treat gender dysphoria, including hormone treatment and surgery when medically indicated, for adolescents and adults.

49. The SOC 8 is based upon a rigorous and methodological evidence-based approach. (Coleman, et al., 2022). Its recommendations are evidence-based, informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options, as well as expert consensus. The process for development of SOC 8 incorporated recommendations on clinical practice guideline development from the National Academies of Medicine and The World Health Organization. Its recommendations were graded using a modified GRADE methodology (Guyatt, et al., 2011), considering the available evidence supporting interventions, risks and harms, and feasibility and acceptability.

50. A clinical practice guideline from the Endocrine Society (the Endocrine Society Guidelines) provides similar widely-accepted protocols for the medically necessary treatment of gender dysphoria. (Hembree, et al., 2017).

51. Each of these guidelines are evidence-based and supported by scientific research and literature, as well as extensive clinical experience.

52. Each of these guidelines also provides distinct guidance for age-appropriate care for children, adolescents, and adults with gender dysphoria. And none of these guidelines recommend medical treatment for prepubertal children, meaning no medical treatment is recommended until after the onset of puberty.

53. The protocols and policies set forth by the WPATH Standards of Care and the Endocrine Society Guidelines are endorsed and cited as authoritative by the major professional medical and mental health associations in the United States, including the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, the American College of Obstetrics and Gynecology, the American College of Physicians, and the World Medical Association, among others.

D. Assessment and Treatment of Gender Dysphoria in Children

54. As with all health care, treatment of prepubertal gender diverse children is individualized based on the needs of the child and the family and other psychosocial considerations and is decided upon only after a discussion of possible benefits and risks (Hidalgo, et al., 2013).

55. The term "gender diverse" includes transgender children as well as children who will ultimately not identify as transgender later in life (Coleman, et al., 2022).

56. As part of those discussions, the child and their family are advised that prepubertal gender diverse children do not always go on to identify as transgender when they reach adolescence, and that children are encouraged to continue developing an understanding of their gender identity without expectation of a specific outcome even after social transition takes place (American Psychological Association, 2015; Edwards-Leeper and Spack, 2012).

57. The Standards of Care and clinical practice guidelines state that prepubertal gender diverse children "are not eligible to access medical intervention," and therefore focuses on developmentally appropriate psychosocial practices (Coleman, et al., 2022; Hembree, et al., 2017).

E. Assessment and Treatment of Gender Dysphoria in Adolescents

58. Under the WPATH Standards of Care and Endocrine Society Guidelines, no medical or surgical treatments are provided before the onset of puberty.[3]

59. If medically indicated, adolescents with gender dysphoria who have entered puberty may be prescribed puberty-delaying medications (GnRHa) to prevent the distress of developing permanent, unwanted physical characteristics that do not align with the adolescent's gender identity. Puberty-delaying medications allow the adolescent time to better understand their gender identity, while delaying distress from the progression of the development of secondary sex characteristics such as breasts or facial hair.

60. Prior to initiation of puberty-delaying medications, providers counsel patients and their families extensively on potential benefits and risks. The intended benefit of treatment is to reduce the risk of worsening gender dysphoria and mental health deterioration. The goal in using puberty-delaying medications is to minimize the patient's dysphoria related to progression of puberty and allow for later initiation of puberty consistent with gender identity. The pubertal stage and individual needs of the patient direct conversations regarding care options.

61. If medically indicated, adolescents may start treatment with hormones (testosterone for transgender boys, estrogen and testosterone suppressants for transgender girls). Eligibility and medical necessity are determined case-by-case, based on an assessment of the adolescent's unique cognitive and emotional maturation and ability to provide a knowing and informed assent in addition to the informed consent of the legal medical decision maker, most often the parent or guardian. As with puberty-delaying medications, the risks and benefits of hormone treatment are discussed with the patient and their families, prior to initiation of gender affirming hormone therapy.

[3] Coleman 2022 at S64; Hembree 2017 at 3881.

62. Under the WPATH Standards of Care, puberty-delaying medication for transgender adolescents who reach the beginning of puberty and gender-affirming hormone therapy for older adolescents may be medically indicated if the following criteria are met: (a) Gender diversity/incongruence is marked and sustained over time; (b) Meets the diagnostic criteria of gender dysphoria; (c) Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment; (d) Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed sufficiently so that gender-affirming medical treatment can be provided optimally; and (e) Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility (Coleman, et al., 2022).

63. Puberty-delaying medications and gender-affirming hormones are prescribed only after a comprehensive psychosocial assessment by a qualified mental health professional who (i) assesses for the diagnosis of gender dysphoria and any other co-occurring diagnoses, (ii) ensures the child can assent and the parents/guardians can consent to the relevant intervention after a thorough review of the risks, benefits and alternatives of the intervention, and (iii) if co-occurring mental health conditions are present, that they do not interfere with the accuracy of the diagnosis of gender dysphoria or impair the ability of the adolescent to assent to care (Coleman, et al., 2022; Hembree, et al., 2017).

64. A comprehensive assessment is a critical element of providing care before any medically necessary medical or surgical intervention for adolescents with gender dysphoria. The assessment should include gender identity development, social development and support, diagnostic assessment of co-occurring mental health or developmental concerns, and capacity for decision-making. SOC 8 also highlights the importance of involving parent(s)/guardian(s) in the assessment and treatment process for minors (Coleman, et al., 2022).

65. In my own practice, I have had patients who presented with some symptoms of gender dysphoria, but who ultimately did not meet the diagnostic criteria for a variety of reasons, and therefore I recommended treatments other than gender-affirming care to alleviate their psychological distress. I have also seen patients that did meet the diagnostic criteria for gender dysphoria but had mental health impairments that precluded proceeding with gender affirming hormonal and surgical care.

66. Some transgender people who do not come forward until adolescence may have experienced symptoms of gender dysphoria for long periods of time but been uncomfortable disclosing those feelings to parents. Other transgender people do not experience distress until they experience the physical changes accompanying puberty. In either case, gender-affirming care requires a comprehensive assessment and persistent, sustained gender dysphoria before medical treatment is recommended to be prescribed.

67. Under the SOC 8, the precise nature of the comprehensive assessment may vary depending on the individual circumstances of the adolescent so long as the assessment effectively obtains information about the adolescent's strengths, vulnerabilities, diagnostic profile, and individual needs. In some cases, a more extended assessment process may be appropriate, such as for youth with more complex presentations (e.g., complicating mental health histories, co-occurring autism spectrum characteristics, and/or an absence of experienced childhood gender incongruence before puberty).

68. Thus, gender-affirming treatment also requires a careful and thorough assessment of a patient's mental health, including co-occurring conditions, history of trauma, and substance use, among many other factors (Olson-Kennedy, et al., 2019; Edwards-Leeper and Spack, 2012). Providers should have the training and experience to distinguish between Gender Dysphoria and other mental health conditions or developmental anxieties (Coleman, et al., 2022).

69. While addressing mental health concerns is important during the course of medical treatment, it does not mean all mental health challenges can or should be resolved completely. Rather, such conditions should not impair the ability of the patient to make an informed decision or interfere with the accuracy of the diagnosis of Gender Dysphoria. Indeed, some co-occurring conditions (for example, Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder, to name a few) could be chronic disorders where complete resolution is impossible and the goal of treatment is mitigating harm and improving functioning.

70. Further, it is important to note that distress associated with untreated gender dysphoria can also amplify co-occurring conditions that developed independently of the gender dysphoria. Thus, treating the underlying gender dysphoria is essential to alleviating the psychological distress associated with co-occurring conditions.

F. Efficacy of Gender-Affirming Treatment for Gender Dysphoria in Adolescents

71. "For some youth, obtaining gender-affirming medical care is important while for others these steps might not be necessary." (Coleman, et al., 2022). In my clinical experience, some adolescent patients have a critical need for medical interventions at or at some point after the onset of puberty and others do not. As with all medical interventions, it is highly individualized and responsive to the specific medical and mental health needs of each patient.

72. Studies, including peer-reviewed cross-sectional and longitudinal studies, demonstrate the positive impact of pubertal suppression in adolescents with gender dysphoria on psychological functioning and quality of life, including a decrease in behavioral and emotional problems, a decrease in depressive symptoms, and improvement in general functioning (e.g., Achille, et al., 2020; Turban, et al., 2020a; van der Miesen, et al., 2020; Costa, et al., 2015; de Vries, et al., 2011b). Furthermore, studies show improvements in body satisfaction with gender-

affirming treatment, and the extant literature recognizes that the body satisfaction is a mediator for improved quality of life and mental health outcomes. (Chen, et al., 2023).

73. In my own practice, I have had patients describe pubertal suppression as lifesaving and a vast majority have experienced a great deal of relief when the treatment is initiated. In contrast to assertions that starting pubertal suppression is a one-way road to hormones, I have also had patients who, through gender affirming psychotherapy, came to understand their gender identity to be congruent with their sex assigned at birth and discontinued this treatment with a resumption of puberty. While each patient and each family is unique, a thorough assessment and a clear discussion of the risks, benefits and alternatives of this interventions is consistent among all of my patients.

74. As with the use of puberty-delaying medications, treatment of gender dysphoria with testosterone or estrogen is highly beneficial for both short-term and long-term psychological functioning of adolescents with gender dysphoria and withholding treatment from those who need it is harmful (e.g., Achille, et al., 2020; Allen, et al., 2019; Chen, et al., 2023; de Lara, et al., 2020; de Vries, et al., 2014; Grannis, et al., 2021; Green, et al., 2022; Kaltiala, et al., 2020; Kuper, et al., 2020; Olsavsky, et al., 2023).

75. In my own practice, I have seen youth with severe gender dysphoria who avoided all social contacts who were able to thrive with the initiation of gender affirming hormones and feel confident with the changes seen as they developed secondary sex characteristics aligned with their gender identity. I have seen my patients start hormones and find themselves more able to build social and romantic relationships.

76. For some older transgender adolescents, surgery may be provided prior to age 18 if medically indicated (typically, chest surgery for transgender male adolescents). Peer-reviewed research has also shown improvements in mental health following gender-affirming chest surgery

for transgender males with gender dysphoria where medically indicated (Mehringer, et al., 2021; Olson-Kennedy, et al., 2018).

77. By contrast, there are no studies supporting speculation that an adolescent's gender dysphoria can be resolved by therapy alone or that such treatment is likely to have better outcomes for adolescents with gender dysphoria. And, as discussed above, to the extent that the goal of therapy is to encourage minors to identify with their sex assigned at birth, such therapies have been shown to be ineffective, harmful, and unethical.

78. In my own practice, I have seen firsthand countless times the benefits that adolescents can have when they get access to safe and necessary gender-affirming medical care. I have had patients that had worsening thoughts of suicide every time they would near menstruation that completely resolved when puberty suppression was initiated. I have had patients who had previously been admitted to psychiatric hospitalizations and received multiple psychiatric medications improve to the point that those medications were no longer necessary after finding family support and receiving gender-affirming hormones. If there was space, I could include hundreds of such stories of adolescents who, with access to appropriate care, began to thrive and engage with the family, their friends and in their schools and communities.

G. Specific Observations and Criticisms for Justifications for the SB 14

79. The House Research Organization published a bill analysis of SB 14 on May 12, 2023, that lists the justifications for the Ban. None of these arguments have merit, however.

80. The bill analysis notes that supporters argue that "[c]hildren and adolescents are not able to give fully informed consent for such serious treatment," but this misrepresents how medical care is provided to adolescents with gender dysphoria. When dealing with adolescent minor patients, it is the parents or legal guardians of the patient who provide consent while the adolescent patient provides assent. Moreover, the WPATH Standards of Care recommend that

prior to the initiation of any medical intervention a provider determine whether the adolescent "demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment" (Coleman, et al., 2022).

81. Likewise, supporters argue that "in many cases adolescent gender dysphoria resolves itself over time." Presumably, in making such an argument, supporters refer (incorrectly) to the notion of desistance. The notion of desistance, however, is not generally applied to transgender people once they reach puberty. Indeed, the desistance studies to which supporters of laws like the Act usually refer are studies pertaining to *prepubertal/preadolescent* youth diagnosed under the now obsolete and overly broad categorizations contained in the DSM III-R and DSM IV for "Gender Identity Disorder in Children." But a child could meet criteria for the DSM III-R or DSM-IV diagnosis of gender identity disorder without identifying as transgender because the diagnostic criteria did not require identification with a gender other than the one assigned to the person at birth. This problem with the diagnosis was remedied with the new DSM-5 diagnosis of "Gender Dysphoria in Children," which requires a child to have "a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)." Given the broader criteria used at the time, it is unsurprising that these studies demonstrated that most children who exhibited gender-nonconforming behavior did not go on to have a transgender identity in adolescence. To be clear, not only do none of the studies pertaining to desistance use the current DSM-5 gender dysphoria diagnosis, they also do not pertain to adolescents or adults, which are the patients who are eligible for gender-affirming medical care. And studies show that if gender dysphoria is present in adolescence, it usually persists (e.g., de Vries, et al., 2011).

82. The bill analysis likewise sets forth the Act's supporters argument that "[t]here is not conclusive evidence to suggest that treatments aimed at physical transition are effective in

resolving dysphoria." This is not true. As noted throughout this declaration, there is ample scientific literature documenting studies and years of clinical experience documenting the effectiveness of gender-affirming medical care.

83. The House Research Organization's bill analysis likewise notes the Act's supporters' argument that "[p]rofessional counseling remains the best and most scientifically supported treatment for minors with gender dysphoria." There is absolutely no evidence counseling alone is sufficient to resolve adolescent patient's gender dysphoria particularly when medical interventions are medically indicated for such patient.

84. Finally, the bill analysis makes reference to the Act's supporters' argument that "[r]egulatory authorities in several European nations where gender-related healthcare is long established have begun to reverse support for hormonal gender-related treatment for minors based on a lack of supporting evidence in systematic reviews." Presumably, this is in reference to limited restrictions in *how* gender-affirming medical care is provided to adolescents with gender dysphoria in a small handful of countries (like Finland and Sweden). However, none of these countries have banned the provision of this gender-affirming medical care to adolescents with gender dysphoria; rather, these countries have modified how this care is provided to adolescents based in part on their centralized health care systems—something that does not exist in the United States. Moreover, Europe is made up of many more countries than the small handful of countries to which the Act's supporters refer. Most European countries provide access to and coverage for gender-affirming care based on the same evidence available to everyone.

H. Prohibiting Access to Gender-Affirming Medical Care Harms Transgender People

85. In enacting the Ban, the Texas legislature and the Governor not only ignore the volumes of data showing the efficacy of gender-affirming medical care, but also the undeniable

fact that there are transgender adolescents that persist into transgender adults and who benefit from this care.

86. The Texas legislature and the Governor also completely ignore the harms associated with prohibiting access to gender-affirming care to adolescents and adults with gender dysphoria for whom it is necessary and appropriate. They also ignore the harmful effects of governmental actions like the Rule.

87. The overarching goal of treatment for gender dysphoria is to eliminate clinically significant distress. For some, this is achieved by aligning an individual patient's body and presentation with their internal sense of self. The denial of medically indicated care to transgender adolescents not only frustrates this goal and results in the prolonging of their gender dysphoria, but also causes additional distress and poses other health risks, such as depression, trauma, self-harm, and suicidality.

88. Lack of access to gender-affirming care therefore directly contributes to poorer mental health outcomes for transgender people (Owen-Smith, et al., 2018).

89. It is also well documented that experiencing discrimination has negative impacts on people's mental health and wellbeing. For example, a 2019 study found that experiencing discrimination in health care settings posed a unique risk factor for heightened suicidality among transgender people, a population already at heightened risk compared with the general population (Herman, et al., 2019). And of note, the 2022 National Survey on LGBTQ Youth Mental Health found that LGBTQ youth who had experienced discrimination based on sexual orientation or gender identity had attempted suicide in the past year at nearly three times the rate as those who had not (19% vs. 7%) (The Trevor Project, 2022).

90. In addition, the 2022 National Survey on LGBTQ Youth Mental Health found that 93% of transgender and nonbinary youth said that they have worried about transgender people

being denied access to gender-affirming medical care due to state or local laws (The Trevor Project, 2022).

91. Research has shown that the mere introduction, debate, and adoption of discriminatory laws like the Ban negatively affects the mental health of transgender youth. A prospective study with sexual minority populations found that living in states with discriminatory policies was associated with a statistically significant increase in the number of psychiatric disorder diagnoses (Hatzenbuehler, et al., 2010). Other studies have "shown that restrictive laws and policies are related to destructive health behaviors on the part of transgender individuals" (Cunningham, et al., 2022; Du Bois, et al., 2018).

92. Recent surveys show the negative toll that anti-LGBTQ measures, like the Ban, and debates surrounding them have had on the mental health of transgender youth. For example, in a survey of youth in November 2022, 86% of transgender and nonbinary youth said that the debates about anti-transgender bills had negatively impacted their mental health (Movement Advancement Project, 2023; The Trevor Project and Morning Consult, 2023). And a study from 2022, though with limitations, showed that the passage of anti-transgender bills is linked with Internet searches related to depression and suicide (Cunningham, et al., 2022).

93. Perhaps, more poignantly, those of us with clinical experience hear from our patients about how it feels to be targeted with this kind of legislation. As two of my transgender patients expressed to me within the past few weeks, "why does everyone hate me just for existing?" and "it's a hard time to be transgender right now."

CONCLUSION

94. By prohibiting access to necessary, safe, and effective medical care as treatment for gender dysphoria, the Texas legislature and governor endanger the health and wellbeing of transgender youth in Texas. But discriminating against transgender adolescents, or withholding

gender-affirming care, will not prevent them from being transgender. To the contrary, as noted previously, stigma, discrimination, and denial of care have been shown to have a profoundly harmful impact on the mental health of transgender people and other minority groups (Hughto, et al., 2015; Owen-Smith, et al., 2018).

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

Executed this 11th day of July 2023.

Aron Janssen
Signed on 2023/07/11 11:18:52 -6:00

Aron Janssen, M.D.

JURAT

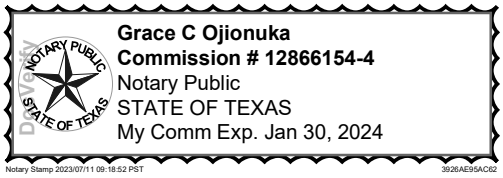
State of TEXAS)
)
County of HARRIS)

Before me, a notary public, on this day personally appeared, Aron Janssen, M.D., known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the foregoing instrument, and being first duly sworn by me states that the statements contained in the foregoing are true and correct to the best of his knowledge, information, and belief.

Sworn to and subscribed before me on the 11th day of July 2023, by Aron Janssen, M.D.

IN TESTIMONY WHEREOF, I have set my hand and affixed my official seal on the day and year first written above.

Notary Public, State of Texas



Notarial act performed by audio-visual communication

EXHIBIT A

Curriculum vitae

Curriculum Vitae

Aron Janssen, M.D.
312-227-7783
aronjans@gmail.com

Personal Data

Born	Papillion, Nebraska
Citizenship	USA

Academic Appointments

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

Education

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

Postdoctoral Training

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

Licensure and Certification

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

Academic Appointments

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

Major Committee Assignments

International, National and Regional

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

Psychiatry Residency

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

Medical School

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

Memberships, Offices, and Committee Assignments in Professional Societies

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

Editorial Positions

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

Principal Clinical and Hospital Service Responsibilities

2011-2019	Staff Psychiatrist, Pediatric Consultation Liaison Service
2011-2019	Faculty Physician, NYU Child Study Center
2011-2019	Founder and Clinical Director, NYU Gender & Sexuality Service
2015-2019	Co-Director, Pediatric Consultation Liaison Service
2019-present	Vice Chair, Pritzker Dept of Psychiatry and Behavioral Health
2019-present	Chief Psychiatrist, Gender Development Program

2020-present Medical Director, Outpatient Psychiatry Services

Relevant Program Development

Gender and Sexuality Service

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

-first mental health service dedicated to transgender youth in NYC

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

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

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

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

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

-model has been internationally recognized

Clinical Specialties/Interests

Gender and Sexual Identity Development

Co-Occurring Mental Health Disorders in Transgender children, adolescents and adults

Pediatric Consultation/Liaison Psychiatry

Psychotherapy

-Gender Affirmative Therapy, Supportive Psychotherapy, CBT, MI

Teaching Experience

2002-2006 Course Developer and Instructor, LGBT Health (University of Colorado School of Medicine

2011-2019 Instructor, Cultural Competency in Child Psychiatry (NYU Department of Child and Adolescent Psychiatry) – 4 hours per year

2011-2019 Course Director, Instructor "Sex Matters: Identity, Behavior and Development" – 100 hours per year

2011-2019 Course Director, LGBT Mental Health Elective (NYU Department of Psychiatry) - 50 hours of direct supervision/instruction per year

2011-2019 Course Director, Transgender Mental Health (NYU Department of Child and Adolescent Psychiatry – course to begin in Spring 2018.

2015-2019 Instructor, Gender & Health Selective (NYU School of Medicine) – 4 hours per year.

Academic Assignments/Course Development

New York University Department of Child and Adolescent Mental Health Studies

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

identity development as a result of my mentorship.

NYU Department of Child and Adolescent Psychiatry
-Instructor: Cultural Competency in Child and Adolescent Psychiatry
-Director: LGBTQ Mental Health Elective
World Professional Association of Transgender Health
-Official Trainer: Global Education Initiative – one of two child psychiatrists charged with training providers in care of transgender youth and adults.

Peer Reviewed Publications

1. Janssen, A., Erickson-Schroth, L., "A New Generation of Gender: Learning Patience from our Gender Non-Conforming Patients," Journal of the American Academy of Child and Adolescent Psychiatry, Volume 52, Issue 10, pp. 995-997, October, 2013.
2. Janssen, A., et. al. "Theory of Mind and the Intolerance of Ambiguity: Two Case Studies of Transgender Individuals with High-Functioning Autism Spectrum
3. Janssen A, Huang H, and Duncan C., Transgender Health. February 2016, "Gender Variance Among Youth with Autism: A Retrospective Chart Review." 1(1): 63-68. doi:10.1089/trgh.2015.0007.
4. Goedel WC, Reisner SL, Janssen AC, Poteat TC, Regan SD, Kreski NT, Confident G, Duncan DT. (2017). Acceptability and Feasibility of Using a Novel Geospatial Method to Measure Neighborhood Contexts and Mobility Among Transgender Women in New York City. Transgender Health. July 2017, 2(1): 96-106.
5. Janssen A., et. al., "Gender Variance Among Youth with ADHD: A Retrospective Chart Review," in review
6. Janssen A., et. al., "Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents," Journal of Child & Adolescent Psychology, 105-115, January 2018.
7. Janssen A., et. al., "A Review of Evidence Based Treatments for Transgender Youth Diagnosed with Social Anxiety Disorder," Transgender Health, 3:1, 27–33, DOI: 10.1089/ trgh.2017.0037.
8. Janssen A., et. al., "'The Complexities of Treatment Planning for Transgender Youth with Co-Occurring Severe Mental Illness: A Literature Review and Case Study," Archives of Sexual Behavior, 2019. # 3563492
9. Kimberly LL, Folkers KM, Friesen P, Sultan D, Quinn GP, Bateman-House A, Parent B, Konnoth C, Janssen A, Shah LD, Bluebond-Langner R, Salas-Humara C., "Ethical Issues in Gender-Affirming Care for Youth," Pediatrics, 2018 Dec;142(6).
10. Strang JF, Janssen A, Tishelman A, Leibowitz SF, Kenworthy L, McGuire JK, Edwards-Leeper L, Mazefsky CA, Rofey D, Bascom J, Caplan R, Gomez-Lobo V, Berg D, Zaks Z, Wallace GL, Wimms H, Pine-Twaddell E, Shumer D, Register-Brown K, Sadikova E, Anthony LG., "Revisiting the Link: Evidence of the Rates of Autism in Studies of Gender Diverse Individuals," Journal of the American Academy of Child and Adolescent Psychiatry, 2018 Nov;57(11):885-887.
11. Goedel William C, Regan Seann D, Chaix Basile, Radix Asa, Reisner Sari L, Janssen Aron C, Duncan Dustin T, "Using global positioning system methods to explore mobility patterns and exposure to high HIV prevalence neighbourhoods among transgender women in New York City," Geospatial Health, 2019 Jan; 14(2): 351-356.
12. Madora, M., Janssen, A., Junewicz, A., "Seizure-like episodes, but is it really epilepsy?" Current Psychiatry. 2019 Aug; 18(8): 42-47.

13. Janssen, A., Busa, S., Wernick, J., "The Complexities of Treatment Planning for Transgender Youth with Co-Occurring Severe Mental Illness: A Literature Review and Case Study," Archives of Sexual Behavior. 2019 Oct; 48(7): 2003-2009.
14. Wernick Jeremy A, Busa Samantha, Matouk Kareen, Nicholson Joey, Janssen Aron, "A Systematic Review of the Psychological Benefits of Gender-Affirming Surgery," Urol Clin North Am. 2019 Nov; 46(4): 475-486.
15. Strang, J.F., Knauss, M., van der Miesen, A.I.R., McGuire, J., Kenworthy, L., Caplan, R., Freeman, A.J., Sadikova, E., Zacks, Z., Pervez, N., Balleur, A., Rowlands, D.W., Sibarium, E., McCool, M.A., Ehrbar, R.D., Wyss, S.E., Wimms, H., Tobing, J., Thomas, J., Austen, J., Pine, E., Willing, L., Griffin, A.D., Janssen, A., Gomez-Lobo, A., Brandt, A., Morgan, C., Meagher, H., Gohari, D., Kirby, L., Russell, L., Powers, M., & Anthony, L.G., (in press 2020). A clinical program for transgender and gender-diverse autistic/neurodiverse adolescents developed through community-based participatory design. *Journal of Clinical Child and Adolescent Psychology.* DOI 10.1080/15374416.2020.1731817
16. Coyne, C. A., Poquiz, J. L., Janssen, A., & Chen, D. Evidence-based psychological practice for transgender and non-binary youth: Defining the need, framework for treatment adaptation, and future directions. Evidence-based Practice in Child and Adolescent Mental Health.
17. Janssen, A., Voss, R.. Policies sanctioning discrimination against transgender patients flout scientific evidence and threaten health and safety. Transgender Health.
18. Dubin, S., Cook, T., Liss, A., Doty, G., Moore, K., Janssen, A. (In press 2020). Comparing Electronic Health Records Domains' Utility to Identify Transgender Patients. Transgender Health, DOI 10.1089/trgh.2020.0069
19. Busa, S., Wernick, J.,…Janssen, A. A Descriptive Case Study of a Cognitive Behavioral Therapy Group Intervention Adaptation for Transgender Youth With Social Anxiety Disorder, Behavioral Therapy, April, 2022
20. Ramsden SC, Pergjika A, Janssen AC, Mudahar S, Fawcett A, Walkup JT, Hoffmann JA. A Systematic Review of the Effectiveness and Safety of Droperidol for Pediatric Agitation in Acute Care Settings. Acad Emerg Med. May, 2022.
21. Janssen, A., Walkup, J., More is Not Always Better, When Different is Required, J Am Acad Child Adolesc Psychiatry. June, 2022 doi: 10.1016/j.jaac.2022.05.006.
22. Wanta, J., Gianakakos, G., Belfort, A., Janssen, A., Considering "Spheres of Influence" in the Care of LGBTQ Youth, CAP Clinics of North America. Volume 31, Issue 4, p649-664, October 2022 doi: 10.1016/j.chc.2022.05.008
23. Coleman, E., Radix, A…. Janssen, A., et. al., Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. International Journal of Transgender Health, 23:sup1, S1-2259, September 2022. doiL 10.1080/26895269.2022.2100644
24. Westley, L., Richey, K.,.. Janssen, A., Using Hospital Incident Command Systems to Respond to the Pediatric Mental and Behavioral Health Crisis of the COVID-19 Pandemic, Journal of Nursing Administration, Feb 2023.

Published Abstracts

1. Thrun, M., Janssen A., et. al. "Frequency of Patronage and Choice of Sexual Partners may Impact Likelihood of HIV Transmission in Bathhouses," original research poster

presented at the 2007 Conference on Retroviruses and Opportunistic Infections, February, 2007.

2. Janssen, A., "Advocating for the mental health of Lesbian, Gay, Bisexual and Transgender (LGBT) population: The Role of Psychiatric Organizations." Workshop for the American Psychiatric Association Institute of Psychiatric Services Annual Meeting, October 2012.
3. Janssen, A., "Gender Variance in Childhood and Adolescents: Training the Next Generation of Psychiatrists," 23rd Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, February 2014.
4. Janssen, A., "When Gender and Psychiatric Acuity/Comorbidities Overlap: Addressing Complex Issues for Gender Dysphoric and Non-Conforming Youth," AACAP Annual Meeting, October 2014.
5. Janssen, A., "Patient Experiences as Drivers of Change: A unique model for reducing transgender health disparities as an academic medical center," Philadelphia Transgender Health Conference, June 2016.
6. Janssen, A., "How much is too much? Assessments & the Affirmative Approach to TGNC Youth," 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.
7. Janssen, A., "Trauma, Complex Cases and the Role of Psychotherapy," 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.
8. Janssen, A., "Gender Variance Among Youth with Autism: A Retrospective Chart Review," Research Poster, 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.
9. Janssen, A., "Gender Fluidity and Gender Identity Development," Center for Disease Control – STD Prevention Conference, September 2016.
10. Janssen, A., "Transgender Identities Emerging During Adolescents' Struggles With Mental Health Problems," AACAP Annual Conference, October 2016.
11. Janssen, A., "How Much is Too Much? Assessments and the Affirmative Approach to Transgender and Gender Diverse Youth," US Professional Association for Transgender Health Inaugural Conference, Los Angeles, February 2017.
12. Janssen, A., "Trauma, Complex Cases and the Role of Psychotherapy," US Professional Association for Transgender Health Inaugural Conference, Los Angeles, February 2017.
13. Sutter ME, Bowman-Curci M, Nahata L, Tishelman AC, Janssen AC, Salas-Humara C, Quinn GP. Sexual and reproductive health among transgender and gender-expansive AYA: Implications for quality of life and cancer prevention. Oral presentation at the Oncofertility Consortium Conference, Chicago, IL. November 14, 2017.
14. Janssen, A., Sidhu, S., Gwynette, M., Turban, J., Myint, M., Petersen, D., "It's Complicated: Tackling Gender Dysphoria in Youth with Autism Spectrum Disorders from the Bible Belt to New York City," AACAP Annual Conference, October 2017.
15. May 2018: "A Primer in Working with Parents of Transgender Youth," APA Annual Meeting.
16. October 2018: "Gender Dysphoria Across Development" – Institute for AACAP Annual Conference.

17. November 2018: "Gender Variance Among Youth with Autism," World Professional Association for Transgender Health Biannual Conference.
18. March 2019: "Gender Trajectories in Child and Adolescent Development and Identity," Austin Riggs Grand Rounds.
19. Janssen, A., et. al., "Ethical Principles in Gender Affirming Care," AACAP Annual Conference, October 2019.
20. Janssen, A., "Gender Diversity and Gender Dysphoria in Youth," EPATH Conference, April 2019
21. Englander, E., Janssen A., et. al., "The Good, The Bad, and The Risky: Sexual Behaviors Online," AACAP Annual Conference, October 2020
22. Englander, E., Janssen, A., et. al., "Love in Quarantine," AACAP Annual Conference, October 2021
23. Janssen, A., Leibowitz, S., et. al., "The Evidence and Ethics for Transgender Youth Care: Updates on the International Standards of Care, 8th Edition," AACAP Annual Conference, October 2021
24. Turban, J., Janssen, A., et. al., "Transgender Youth: Understanding "Detransition," Nonlinear Gender Trajectories, and Dynamic Gender Identities," AACAP Annual Conference, October 2021
25. Hoffmann JA, Pergjika, A, Liu X, Janssen AC, Walkup JT, Alpern ER, Johnson EJ, Corboy JB. Standardizing and Optimizing Care for Pediatric Acute Agitation Management in the Emergency Department. Oral Abstract Presentation. Academic Pediatric Association Annual Conference on Advancing Quality Improvement Science for Children's Healthcare. New Orleans. Accepted for presentation on April 22, 2022.
26. Janssen, A., Malpas, J., Glaeser, E., "Family-Based Interventions with Transgender and Gender Nonbinary Youth," World Professional Association of Transgender Health 27th Scientific Symposium, September 2022.
27. Tishelman, A., Janssen A., et. al., WPATH Standards of Care – "Child Chapter," World Professional Association of Transgender Health 27th Scientific Symposium, September 2022
28. Janssen, A., Leibowitz, S., et al, "The Evidence and Ethics for Transgender Youth Care: Updates on the New International Standards of Care, Eighth Edition. AACAP Annual Conference, October 2022.
29. Turban, J., Janssen, A., et al, "Transgender Youth: Evolving Gender Identities and "Detransition," AACAP Annual Conference, October 2022.

Books

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

Book Chapters

1. Janssen, A., Shatkin, J., "Atypical and Adjunctive Agents," Pharmacotherapy for Child and Adolescent Psychiatric Disorders, 3rd Edition, Marcel Dekker, Inc, New York, 2012.
2. Janssen, A; Liaw, K: "Not by Convention: Working with People on the Sexual & Gender Continuum," book chapter in The Massachusetts General Hospital Textbook on Cultural Sensitivity and Diversity in Mental Health. Humana Press, New York, Editor R. Parekh, January 2014.

3. Janssen, A; Glaeser, E., Liaw, K: "Paving their own paths: What kids & teens can teach us about sexual and gender identity," book chapter in Cultural Sensitivity in Child and Adolescent Mental Health, MGH Psychiatry Academy Press, Editor R. Parekh, 2016
4. Janssen A., "Gender Identity," Textbook of Mental and Behavioral Disorders in Adolescence, February 2018.
5. Busa S., Wernick, J., & Janssen, A. (In Review) Gender Dysphoria in Childhood. Encyclopedia of Child and Adolescent Development. Wiley, 2018.
6. Janssen A., Busa S., "Gender Dysphoria in Childhood and Adolescence," Complex Disorders in Pediatric Psychiatry: A Clinician's Guide, Elsevier, Editors Driver D., Thomas, S., 2018.
7. Wernick J.A., Busa S.M., Janssen A., Liaw K.RL. "Not by Convention: Working with People on the Sexual and Gender Continuum." Book chapter in The Massachusetts General Hospital Textbook on Diversity and Cultural Sensitivity in Mental Health, editors Parekh R., Trinh NH. August, 2019.
8. Weis, R., Janssen, A., & Wernick, J. The implications of trauma for sexual and reproductive health in adolescence. In *Not Just a nightmare: Thinking beyond PTSD to help teens exposed to trauma.* 2019
9. Connors J., Irastorza, I., Janssen A., Kelly, B., "Child and Adolescent Medicine," The Equal Curriculum: The Student and Educator Guide to LGBTQ Health, editors Lehman J., et al. November 2019.
10. Janssen, A., et. al., "Gender and Sexual Diversity in Childhood and Adolescence," Dulcan's Textbook of Child and Adolescent Psychiatry, 3rd edition, editor Dulcan, M., (in press)
11. Busa S., Wernick J, Janssen, A., "Gender Dysphoria," The Encyclopedia of Child and Adolescent Development, DOI: 10.1002/9781119171492. Wiley, December 2020.

Invited Academic Seminars/Lectures

1. April 2006: "How to Talk to a Gay Medical Student" – presented at the National AAMC Meeting.
2. March 2011: "Kindling Inspiration: Two Model Curricula for Expanding the Role of Residents as Educators" – workshop presented at National AADPRT Meeting.
3. May 2011: Janssen, A., Shuster, A., "Sex Matters: Identity, Behavior and Development," Grand Rounds Presentation, NYU Department of Child and Adolescent Psychiatry.
4. March 2012: Janssen, A., Lothringer, L., "Gender Variance in Children and Adolescents," Grand Rounds Presentation, NYU Department of Child and Adolescent Psychiatry.
5. June 2012: Janssen, A., "Gender Variance in Childhood and Adolescence," Grand Rounds Presentation, Woodhull Department of Psychiatry
6. October 2012: "Advocating for the mental health of Lesbian, Gay, Bisexual and Transgender (LGBT) population: The Role of Psychiatric Organizations." Workshop for the American Psychiatric Association Institute of Psychiatric Services Annual Meeting.
7. March 2013: "Gender Variance in Childhood and Adolescence," Sexual Health Across the Lifespan: Practical Applications, Denver, CO.
8. October 18th, 2013: "Gender Variance in Childhood and Adolescence," Grand Rounds Presentation, NYU Department of Endocrinology.

9. October, 2014: GLMA Annual Conference: “Theory of Mind and Intolerance of Ambiguity: Two Case Studies of Transgender Individuals with High-Functioning ASD,” Invited Presentation
10. October 2014: New York Transgender Health Conference: “Mental Health Assessment in Gender Variant Children,” Invited Presentation.
11. November, 2014: Gender Spectrum East: “Affirmative Clinical Work with Gender-Expansive Children and Youth: Complex Situations.”
12. October 2015: “Gender Dysphoria and Complex Psychiatric Co-Morbidity,” LGBT Health Conference, Invited Speaker
13. October 2015: “Transgender Health Disparities: Challenges and Opportunities,” Grand Rounds, Illinois Masonic Department of Medicine
14. November 2015: “Autism and Gender Variance,” Gender Conference East, Invited Speaker
15. February 2016: “Working with Gender Variant Youth,” New York State Office of Mental Health State Wide Grand Rounds, Invited Speaker
16. March, 2016: “Working with Gender Variant Youth,” National Council for Behavioral Health Annual Meeting, Invited Speaker
17. March 2016: “Gender Variance Among Youth with Autism: A Retrospective Chart Review and Case Presentation,” Working Group on Gender, Columbia University, Invited Speaker.
18. September, 2016: “Best Practices in Transgender Mental Health: Addressing Complex Issues for Gender Dysphoric and Non-Conforming Youth,” DeWitt Wallace Institute for the History of Psychiatry, Weill Cornell.
19. October, 2016: “LGBTQ Youth Psychiatric Care,” Midwest LGBTQ Health Symposim
20. October, 2016: “Gender Fluidity and Gender Identity Development,” NYU Health Disparities Conference.
21. February, 2017: “Best Practices in Transgender Mental Health,” Maimonides Grand Rounds
22. March, 2017: “Transgender Health: Challenges and Opportunities,” Invited speaker, Center for Disease Control STD Prevention Science Series.
23. September 2017: “Autism and Gender Dysphoria,” Grand Rounds, NYU Department of Neurology.
24. November 2017: “Consent and Assent in Transgender Adolescents,” Gender Conference East.
25. November 2017: “Transgender Mental Health: Challenges and Opportunities,” Grand Rounds, Lenox Hill Hospital.
26. April 2018: “Gender Trajectories in Childhood and Adolescent Development and Identity,” Sex, Sexuality and Gender Conference, Harvard Medical School.
27. September 2019: “Social and Psychological Challenges of Gender Diverse Youth,” Affirmative Mental Health Care for Gender Diverse Youth, University of Haifa.
28. October 2019: “Best Practices in Transgender Mental Health,” Grand Rounds, Rush Department of Psychiatry.
29. February 2020: “The Overlap of Autism and Gender Dysphoria,” Grand Rounds, Northwestern University Feinberg School of Medicine Department of Psychiatry
30. February 2020: “Gender Dysphoria and Autism,” Grand Rounds, University of Illinois at Chicago Department of Psychiatry
31. September 2021: “Gender Diversity and Autism,” Grand Rounds, Kaiser Permanente Department of Pediatrics

32. October 2021: Gender Dysphoria and Autism," Grand Rounds, Case Western Reserve University Department of Psychiatry.

Selected Invited Community Seminars/Lectures

1. April 2012: "Gender and Sexuality in Childhood and Adolescence," Commission on Race, Gender and Ethnicity, NYU Steinhardt Speakers Series.
2. February 2013: "Supporting Transgender Students in School," NYC Independent School LGBT Educators Panel, New York, NY.
3. June 2013: "LGBT Health," Presentation for Neuropsychology Department
4. August 2013: "Chronic Fatigue Syndrome: Etiology, Diagnosis and Management," invited presentation.
5. September 2013: Panelist, "LGBTQ Inclusive Sex Education."
6. April 2015: Transgender Children, BBC News, BBCTwo, invited expert
7. January 2016: Gender Dysphoria and Autism – Ackerman Podcast - http://ackerman.podbean.com/e/the-ackerman-podcast-22-gender-dysphoria-autism-with-aron-janssen-md/
8. February 2016: "Best Practices in Transgender Mental Health," APA District Branch Meeting, Invited Speaker.
9. May 2016: "Best Practices in Transgender Mental Health," Washington D.C., District Branch, APA, Invited Speaker
10. July 2016: "Transgender Youth," Union Square West
11. November 2017: "Understanding Gender: Raising Open, Accepting and Diverse Children," Heard in Rye, Conversations in Parenting.
12. January 2018: "The Emotional Life of Boys," Saint David's School Panel, Invited Speaker
13. June 2018: "Supporting Youth Engaged in Gender Affirming Care," NYU Child Study Center Workshop.
14. October 2018: "Medicine in Transition: Advances in Transgender Mental Health," NYCPS HIV Psychiatry and LGBT Committee Meeting.
15. October 2018: "Understanding Gender Fluidity in Kids," NYU Slope Pediatrics.
16. October, 2021: Issues of Ethical Importance: Health Care for Pediatric LGBTQ+ Patients, American Medical Association, Invited Talk

Major Research Interests

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

Research Studies

Study Title	IRB Study#	Dates
Suicide Attempts Identified in a Children's Hospital Before and During COVID-19	2021-4428	2/26/21-present
Lurie Children's Sex & Gender Development Program Clinical Measure Collection	2019-2898	2019-present

Adolescent Gender Identity Research Study (principal investigator) - unfunded	s15-00431	4/15-5/19
Co-Occurrence of Autism Spectrum Disorders and Gender Variance: Retrospective Chart Review (principal investigator) - unfunded	s14-01930	10/14-5/19
Expert Consensus on Social Transitioning Among Prepubertal Children Presenting with Transgender Identity and/or Gender Variance: A Delphi Procedure Study (principal investigator) - unfunded	s13-00576	3/16-5/19
Co-Occurrence of ADHD/Gender Dysphoria (principal investigator) - unfunded	s16-00001	1/16-5/19
PICU Early Mobility- unfunded	s16-02261	12/16-5/19
Metformin for Overweight and Obese Children and Adolescents with Bipolar Spectrum Disorders Treated with Second-Generation Antipsychotics – Funded by PCORI	s16-01571	8/16-5/19

Other

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

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

Selected Media Appearances:

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

EXHIBIT B

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Exhibit 17

CAUSE NO.

LAZARO LOE, *et al.*,	§	
	§	
Plaintiffs,	§	
v.	§	IN THE DISTRICT COURT OF
	§	TRAVIS COUNTY, TEXAS
THE STATE OF TEXAS, *et al.*,	§	____ JUDICIAL DISTRICT
	§	
Defendants.	§	
	§	
	§	

EXPERT AFFIDAVIT OF JOHANNA OLSON-KENNEDY, M.D., M.S.

I, Johanna Olson-Kennedy, M.D., M.S., hereby declare and state as follows:

1. I am over 18 years of age, of sound mind, and in all respects competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. The opinions expressed herein are my own and do not express the views or opinions of my employer.

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

BAKCGROUND AND QUALIFICATIONS

A. Qualifications and Experience

4. I am a double board-certified physician in Pediatrics and Adolescent Medicine. I specialize in the care of transgender youth and gender diverse children. I am a recognized expert in this field.

5. I received my Doctor of Medicine (M.D.) degree from the Chicago Medical School in 1997. In 2000, I completed my residency in pediatrics at the Children's Hospital of Orange

County, California. In 2003, I completed a three-year fellowship in adolescent medicine at Children's Hospital Los Angeles.

6. I have been a licensed physician in California since 2000.

7. I am currently the Medical Director of the Center for Transyouth Health and Development, in the Division of Adolescent Medicine at Children's Hospital Los Angeles in California. The Center is the largest clinic in the United States for transgender youth and gender diverse youth and provides them with both medical and mental health services, including consultation and support for families with transgender and gender diverse children; gender-affirming medical treatments, when indicated, including medications to suppress puberty in peri-pubertal youth (i.e., youth at the onset of puberty) and gender-affirming hormone used for masculinization or feminization; as well as surgical referrals when indicated. Under my direction, the Center conducts rigorous research aimed at understanding the experience of gender diversity and gender dysphoria from childhood through early adulthood.

8. Over the course of my work with this population during the past 17 years, I have provided services for approximately 1,200 young people and their families, and currently have an active panel of around 650 patients of varying ages, up to 25 years old.

9. I have been awarded research grants to examine the impact of early interventions including puberty-delaying medication (commonly known as puberty blockers) and gender-affirming hormones on the physiological and psychosocial development of gender diverse and transgender youth.

10. I have lectured extensively across the United States and internationally on the treatment and care of gender diverse children and transgender adolescents, the subjects including pubertal suppression, gender-affirming hormone therapy, transitioning teens and the adolescent

experience, age considerations in administering hormones, and the need for, risks, and outcomes of hormonal treatments.

11. I have published over 20 peer-reviewed journal articles on transgender health-related issues, as well as over two dozen additional publications, such as articles, chapters, and editorials, both peer-reviewed and non-peer-reviewed.

12. I am the principal investigator on a multisite National Institutes of Health grant to continue, for an additional 5 years, an ongoing study examining the impact of gender-affirming medical care for transgender youth on physiologic and psychological health and well-being. The first seven years have already been completed. This was the first study of its kind in the U.S. to determine longitudinal outcomes among this population of vulnerable youth. The study to date has yielded approximately 28 manuscripts.

13. I am an Associate Professor at the Keck School of Medicine at the University of Southern California and an attending physician at Children's Hospital Los Angeles.

14. I have been a member of the World Professional Association for Transgender Health ("WPATH") since 2010, and a Board Member of the U.S. Professional Association for Transgender Health ("USPATH") since 2017. In 2022, I was appointed to the Executive Board of the USPATH. I am also a member of the Society for Adolescent Health and Medicine and the American Academy of Pediatrics. In addition, I am a member of the LGBT Special Interest Group of the Society for Adolescent Health and Development.

15. I am the 2014 Recognition Awardee for the Southern California Regional Chapter of the Society for Adolescent Health and Medicine.

16. In 2019, I was invited by the University of Bristol as a Benjamin Meaker visiting professor, the purpose of which is to bring distinguished researchers from overseas to Bristol in order to enhance the research activity of the university.

17. My professional background, experience, publications, and presentations are further detailed in my curriculum vitae ("CV"). A true and correct copy of my most up-to-date CV is attached as **Exhibit A**.

B. Previous Testimony

18. In the last four years, I have testified as an expert at trial or by deposition in the following cases: *Dekker v Weida*, Case No. 4:22-cv-00325-RH-MAF; *Fain v. Crouch*, No. 3:20-cv-00740 (S.D. W.Va.); *Kadel v. Folwell*, Case No. 1:19-cv-00272-LCB-LPA (M.D.N.C.); *Miller v. Purdue* (Colorado); *In the interest of JA.D.Y. and JU.D.Y., Children*, Case No. DF-15-09887 (255th Jud. District Ct., Dallas Cty., Tex.); and *Paul E. v. Courtney F.*, No. FC2010-051045 (Superior Ct., Maricopa Cty., Ariz.).

C. Compensation

19. I am being compensated for my work on this matter at a rate of $200.00 per hour for preparation of declarations and expert reports, as well as any pre-deposition and/or pre-trial preparation and any deposition testimony or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

D. Bases for Opinions

20. In preparing this report, I have relied on my training and years of research and clinical experience, as set out in my CV, and the materials listed in the CV. *See* **Exhibit A**.

21. I have also relied on the published research relating to gender dysphoria and its treatments, including the materials listed in the attached bibliography. *See* **Exhibit B**. The sources

cited therein are authoritative, scientific peer-reviewed publications. Some of these publications are specifically cited as supportive examples in particular sections of this declaration.

22. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I reserve the right to revise and supplement the opinions expressed in this report or the bases for them if any new information becomes available in the future, including as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

23. In addition, I have reviewed the text of Senate Bill 14 (hereafter, "SB 14", "the Act", or "the Ban"), enacted by the 88th Texas legislature and signed into law by Governor on June 2, 2023, as well as the House Research Organization bill analysis of SB 14, dated May 12, 2023.

EXPERT OPINIONS

A. Gender Identity

24. The term gender identity was originally coined in 1964 by American psychiatrist Robert J. Stoller, a noted psychoanalyst who studied sexual orientation, gender identity, and differences in sexual development.[1] Gender identity is a distinct characteristic and is defined as one's internal sense of being male or female (or rarely, both or neither). It has a strong biological basis. Every person has a gender identity.

25. The concept of gender identity is contemporaneously understood both colloquially and within the domain of science and medicine to denote someone's gender. It is a concept well-

[1] Stoller, R.J. (1964). A Contribution to the Study of Gender Identity, *The International journal of psycho-analysis*, 45, 220–226.

understood and accepted in medicine and science. Indeed, gender identity information is commonly collected and reported on within the context of scientific research.[2]

26. The term cisgender refers to a person whose gender identity matches their sex assigned at birth. The term transgender refers to a person whose gender identity does not match their sex assigned at birth.

27. Historically, a person is assigned a sex when they are born, typically in binary fashion (i.e., male or female), based on the appearance of their external genitalia. However, a more contemporary understanding of sex shows that sex comprises multiple characteristics. Among the multiple sex-related characteristics are genitalia, chromosomal makeup, hormones, variations in brain structure and function, and gender identity. For some of these characteristics there is significant variance as reflected by the dozens of intersex mechanisms and varying gender identities. Additionally, not all sex characteristics, including gender identity, are always in alignment. Accordingly, the Endocrine Society Guidelines state that, "As these may not be in line with each other (e.g., a person with XY chromosomes may have female-appearing genitalia), the terms biological sex and biological male or female are imprecise and should be avoided."[3]

28. As early as 1966 it has been understood that gender identity cannot be changed.[4] Efforts to do so have been shown to be unsuccessful and harmful.

B. Gender Dysphoria and its Treatment

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[2] Clayton JA, Tannenbaum C. (2016). Reporting Sex, Gender, or Both in Clinical Research? *JAMA*. 316(18): 1863–1864.

[3] Hembree, W.C., Cohen-Kettenis, P.T., Gooren, L., et al. (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *The Journal of Clinical Endocrinology & Metabolism*, 102(11): 3869–3903.

[4] Benjamin, H. (1966). The Transsexual Phenomenon. New York: The Julian Press, Inc. Publishers.

29. Gender Dysphoria (GD) is a serious medical condition characterized by distress due to a mismatch between assigned birth sex and a person's internal sense of their gender. GD was formerly categorized as Gender Identity Disorder (GID) but the condition was renamed in May 2013, with the release of the American Psychiatric Association (APA)'s fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).[5] In announcing this change, the APA explained that in addition to the name change, the criteria for the diagnosis were revised "to better characterize the experiences of affected children, adolescents, and adults."[6] The APA further stressed that "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."[7]

30. For a person to be diagnosed with GD, there must be a marked difference between the individual's expressed/experienced gender and the gender others would assign to the individual, present for at least six months. In children, the desire to be of the other gender must be present and verbalized.[8] The condition must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

31. The World Professional Association of Transgender Health (WPATH) has clear recommendations for the health of transgender and gender non-conforming people in what is now the *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8* ("SOC

[5] A text revision to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition was published in 2022 ("DSM-5-TR").

[6] DSM-5.

[7] *Id.*

[8] Notably, the DSM-IV included a separate diagnosis for GID in children, which required the child to display a number of behaviors stereotypical of the non-natal gender. That diagnosis, and its list of behavioral requirements, have been deleted from the DSM-5 and replaced by updated and more precise diagnostic criteria.

8").[9] The SOC are based on the best available science and expert professional consensus in transgender health. The SOC-8's recommendation statements were developed based on data derived from independent systematic literature reviews, background reviews, and expert opinions; and its grading of recommendations was based on the available evidence supporting interventions, a discussion of risks and harms, as well as the feasibility and acceptability of these. SOC-8 recommends the provision of medical interventions for adolescents and adults (but not for prepubertal children) with gender dysphoria, based on an individual patient's needs. These medical interventions include puberty-delaying medications, hormone therapy, and surgery.

32. The WPATH SOC have been endorsed and cited as authoritative by the major medical associations in the United States, including the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, the Endocrine Society, the Pediatric Endocrine Society, the American College of Physicians, and the American Academy of Family Physicians, among others.

33. The UCSF Center for Excellence in Transgender Care as well as the Endocrine Society have also both published comprehensive guidelines for the care of transgender and non-binary individuals that are largely consistent with the WPATH SOC.[10]

34. Under the WPATH SOC and other clinical practice guidelines for the treatment of gender dysphoria, care should be provided using an individualized approach.

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[9] Coleman, et al. (2022) (SOC 8).

[10] Deutsch, M.B. (ed.). (2016). Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People (2d ed.). San Francisco, CA: UCSF Center of Excellence for Transgender Health, https://transcare.ucsf.edu/guidelines (UCSF Guidelines); Hembree, et al. (2017) (Endocrine Society Guidelines).

35. **For children who have not yet reached puberty, medical intervention is unnecessary and unwarranted.** After the onset of puberty, medical interventions such as puberty blockers, and later hormones and surgery, may be appropriate.

36. Under the current widely accepted clinical practice guidelines, medical and surgical interventions for adolescents with gender dysphoria are determined by the care team (usually a medical and mental health professional) in collaboration with the patient, and the patient's family, if the patient is a minor after a comprehensive psychological evaluation of the patient. These medical decisions are made by the care team in conjunction with the patient and, if the patient is a minor, the patient's family, and consider the patient's social situation, level of gender dysphoria, developmental stage, existing medical and mental health conditions, and other relevant factors. Sometimes treatment begins with puberty delaying medications (also referred to as puberty blockers), later followed by gender-affirming hormones. The majority of youth, and certainly all adults, accessing treatment are already well into or have completed puberty.

1) Puberty Blockers

37. The beginning signs of puberty in transgender youth (the development of breast buds in assigned birth females and increased testicular volume in assigned birth males) is often a painful and sometimes traumatic experience that brings increased gender dysphoria and the potential development of a host of comorbidities including depression, anxiety, substance abuse, self-harming behaviors, social isolation, high-risk sexual behaviors, and increased suicidality. The development of secondary sex characteristics is a permanent change in an individual's phenotype.

38. Puberty suppression, which involves the administration of gonadotrophin-releasing hormone analogues (GnRHa), essentially pauses puberty, thereby allowing the young person the opportunity to explore gender without having to experience the anxiety and distress associated

with developing undesired secondary sexual characteristics. In addition, for parents/guardians who are uneducated about gender diversity and/or who have only recently become aware of their child's transgender identity, puberty blockers provide additional time and opportunity to integrate this new information into their own experience and to develop skills to support their child. Puberty suppression also has the benefit of potentially rendering obsolete some gender-affirming surgeries down the line, such as male chest reconstruction, tracheal shave, facial feminization, and vocal cord alteration, which otherwise would be required to correct the initial "incorrect" puberty.

39. Puberty suppression has been used safely for decades in children with other medical conditions, including precocious puberty, and is a reversible intervention.[11] Both the Endocrine Society and the WPATH SOC recommend initiation of puberty suppression at the earliest stages of puberty (usually, Tanner 2) (assuming someone has engaged in services before or around this time), regardless of chronological age, in order to avoid the stress and trauma associated with developing secondary sex characteristics of the natal sex. If the medication is discontinued, the young person continues their endogenous puberty.

40. A growing body of evidence, including peer-reviewed cross-sectional and longitudinal studies, demonstrates the positive impact of pubertal suppression in youth with GD on psychological functioning including a decrease in behavioral and emotional problems, a decrease in depressive symptoms, and improvement in general functioning.[12]

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[11] Mul, D. & Hughes, I. (2008). The use of GnRH agonists in precocious puberty. *European journal of endocrinology / European Federation of Endocrine Societies*. 159 Suppl 1. S3-8.

[12] See for example: de Vries, A.L., Steensma, T.D., Doreleijers, T.A., & Cohen-Kettenis, P.T. (2011). Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study. *The Journal of Sexual Medicine*, 8(8), 2276-2283; Turban, J.L., King, D., Carswell, J.M., & Keuroghlian, A.S. (2020). Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*, 145(2):e20191725; van der Miesen, A.I., Steensma, T.D., de Vries, A.L., *et al*. (2020). Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers. *Journal of*

41. The initial follow-up studies evaluating the use of puberty suppression in relation to psychological well-being in adolescents with GD came from the Netherlands and demonstrated that behavioral and emotional problems and depressive symptoms decreased, and general functioning significantly improved during treatment.[13]

42. A study from the United Kingdom demonstrated that a combination of psychological support and puberty suppression were associated with improved psychosocial functioning in adolescents with gender dysphoria than psychological support only.[14]

43. A more recent cross-sectional study from the Dutch team demonstrated that transgender youth undergoing pubertal suppression had better psychological functioning than those youth who had not yet begun puberty blockade.[15]

44. Achille et al. demonstrated a positive effect of puberty blockade on mental health in a small, prospective investigation. The study characterized a treatment cohort over progressive interventions moving from puberty blockade to GAH treatment.[16]

45. Overall, this growing body of evidence is consistent with and supports clinical experience demonstrating a significant positive effect of puberty blockade in youth with gender dysphoria.

Adolescent Health, 66(6), 699-704; Achille, C., Taggart, T., Eaton, N.R., *et al*. (2020). Longitudinal Impact of Gender-Affirming Endocrine Intervention on the Mental Health and Well-Being of Transgender Youths: Preliminary Results. *International Journal of Pediatric Endocrinology*, 2020(8), 1-5; and Costa, R., Dunsford, M., Skagerberg, E., Holt, V., Carmichael, P., & Colizzi, M. (2015). Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. *The journal of sexual medicine*, *12*(11), 2206–2214.

[13] de Vries, et al. (2011); de Vries, et al. (2014).

[14] Costa, et al. (2015).

[15] Van der Miesen, et al. (2020).

[16] Achille, et al. (2020).

46. Over the course of my work with gender diverse and transgender youth during the past 17 years, I have prescribed puberty-delaying medications for over 350 patients. All of those patients have benefitted from putting their endogenous puberty process on pause, even the small handful who discontinued GnRH analogues and went through their endogenous puberty. Many of these young people were able to matriculate back into school environments, begin appropriate peer relationships, and participate meaningfully in therapy and family functions. Children who had contemplated or attempted suicide or self-harm (including cutting and burning) associated with monthly menstruation or the anxiety about their voice dropping were offered respite from those dark places of despair. GnRH analogues for puberty suppression are, in my opinion, a sentinel event in the history of transgender medicine, and have changed the landscape almost as much as the development of synthetic hormones.

47. Puberty blockers, thus, can significantly alleviate and prevent worsening distress of gender dysphoria that frequently comes with puberty.

48. Puberty blockers also afford youth the opportunity to undergo a single, congruent pubertal process and avoid many of the surgical interventions previously necessary to physically align with their gender, and other physical changes that cannot be addressed later by surgery. It is a simple reversible intervention that has the capacity to improve health outcomes and, for some patients, save lives.

2) Gender-Affirming Hormones

49. Cross-gender or gender-affirming hormone therapy involves administering steroids of the experienced sex (i.e., their gender identity) (estrogen for transfeminine individuals and testosterone for transmasculine individuals). The purpose of this treatment is to attain the appropriate masculinization or feminization of the transgender person to achieve a gender

phenotype that matches as closely as possible to their gender identity. Gender-affirming hormone therapy is a partially reversible treatment in that some of the effects produced by the hormones are reversible (e.g., changes in body fat composition, decrease in facial and body hair) while others are irreversible (e.g., deepening of the voice, breast tissue development).

50. Under the widely accepted clinical practice guidelines such as WPATH SOC-8, eligibility and medical necessity should be determined case-by-case, based on an assessment of the youth's unique circumstances and needs and their cognitive and emotional maturation and ability to provide a knowing and informed consent. The decision should be made only after a careful review with the youth and parents/guardians of the potential risks and benefits of hormone therapy, including potential risks to fertility and options for fertility preservation. The youth's primary care provider, therapist, or another experienced mental health professional can help document and confirm the patient's history of GD, the medical necessity of the intervention, and the youth's readiness to transition medically.

51. As with the use of puberty blockers, the data demonstrating the positive effects of gender affirming hormones (GAH), including in adolescents, is well established and growing.[17]

[17] *See*, *e.g.*, Chen, D., Berona, J., Chan, Y. M., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., ... & Olson-Kennedy, J. (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *New England Journal of Medicine*, *388*(3), 240-250; Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS One*, *17*(1), e0261039; Achille, C., Taggart, T., Eaton, N.R., *et al*. (2020). Longitudinal Impact of Gender-Affirming Endocrine Intervention on the Mental Health and Well-Being of Transgender Youths: Preliminary Results. *International Journal of Pediatric Endocrinology*, 2020(8), 1-5; de Lara, D.L., Rodríguez, O.P., Flores, I.C., *et al*. (2020). Psychosocial Assessment in Transgender Adolescents. *Anales de Pediatría (English Edition)*, 93(1), 41-48; and Allen, L.R., Watson, L.B., Egan, A.M., & Moser, C.N. (2019). Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones. *Clinical Practice in Pediatric Psychology*, 7(3), 302-311.

52. The Dutch team at The Center of Expertise on Gender Dysphoria at the VU University Medical Center Amsterdam continued to report out the improvement within their cohort of youth with gender dysphoria after GAH. De Vries et al reported in 2014 that their cohort of young adults who began care in adolescence had steadily improving mental health (including depression, anxiety, anger, internalizing and externalizing psychopathologic symptoms) following puberty blockade, GAH and gender affirming surgery.[18]

53. A German observational study reported that among the participants at follow-up, adolescents in the gender-affirming hormone (GAH) and surgery (GAS) group reported emotional and behavioral problems and physical quality of life scores similar to the German norm mean.[19]

54. Also from Germany, Neider et al. reported that among a group of 75 adolescents with gender dysphoria satisfaction improved the further along the treatment course had progressed.[20]

55. From the United States, Kuper et al. carried out a prospective study and reported their cohort of transgender and non-binary youth starting either pubertal blockade or GAH demonstrated improvement at follow up (around a year) in depression, anxiety and body esteem.[21]

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[18] de Vries, et al. (2014).

[19] Becker-Hebly, I., Fahrenkrug, S., Campion, F., Richter-Appelt, H., Schulte-Markwort, M., & Barkmann, C. (2021). Psychosocial health in adolescents and young adults with gender dysphoria before and after gender-affirming medical interventions: A descriptive study from the Hamburg Gender Identity Service. *European Child & Adolescent Psychiatry*, 30(11), 1755–1767.

[20] Nieder, T. O., Mayer, T. K., Hinz, S., Fahrenkrug, S., Herrmann, L., & Becker-Hebly, I. (2021). Individual treatment progress predicts satisfaction with transition-related care for youth with gender dysphoria: A prospective clinical cohort study. *The Journal of Sexual Medicine*, 18(3), 632–645.

[21] Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy. *Pediatrics*, 145(4).

56. While small, Grannis et al. demonstrated decreased depression and anxiety in a group of transmasculine youth taking testosterone versus an untreated control group.[22]

57. Similarly, Allen et al. followed a cohort of 47 adolescents with gender dysphoria and found statistically significant improvements in general well-being and suicidality, as measured by the National Institutes of Health "Ask Suicide Screening Questions" instrument.[23]

58. Most recently our team at the Trans Youth Care United States (TYC-US) reported in the New England Journal of Medicine an improvement among 315 youth in positive affect and life satisfaction as well as a decrease in depressive and anxiety symptoms after two years of GAH.[24]

59. The data documenting the efficacy of hormone treatment in transgender adults is robust and goes back even further. Numerous longitudinal studies document improvement in various mental health parameters including depression, anxiety, self-confidence, body image and self-image, general psychological functioning.[25]

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[22] Grannis, C., Leibowitz, S. F., Gahn, S., Nahata, L., Morningstar, M., Mattson, W. I., Chen, D., Strang, J. F., & Nelson, E. E. (2021). Testosterone treatment, internalizing symptoms, and body image dissatisfaction in transgender boys. *Psychoneuroendocrinology*, 132, 105358, 1-8.

[23] Allen, L.R., Watson, L.B., Egan, A.M., & Moser, C.N. (2019). Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones. *Clinical Practice in Pediatric Psychology*, 7(3), 302-311.

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

[25] See for example: Colizzi, M., et al. (2014). Transsexual patients' psychiatric comorbidity and positive effect of cross-sex hormonal treatment on mental health: results from a longitudinal study. *Psychoneuroendocrinology*, *39*, 65–73; Colizzi, M., et al. (2013). Hormonal treatment reduces psychobiological distress in gender identity disorder, independently of the attachment style. *The journal of sexual medicine*, *10*(12), 3049–3058; Corda, E., et al. (2016). Body image and gender role perceived in gender dysphoria: Cross-sex hormone therapy effects. *European Psychiatry*, 33(S1), S589-S589; Fisher, A. D., et al. (2016). Cross-Sex Hormone Treatment and Psychobiological Changes in Transsexual Persons: Two-Year Follow-Up Data. *The Journal of clinical endocrinology and metabolism*, *101*(11), 4260–4269; Heylens, G., et al. (2014). Effects of

60. This established and growing body of evidence is consistent with decades of clinical experience demonstrating the positive effect of gender affirming hormones in adolescents and adults with gender dysphoria.

61. Over the past 17 years, I have prescribed gender-affirming hormones for over 1,000 adolescents and young adults. Many of my patients have described the opportunity to align their physical body with their gender as life-saving. Being afforded the opportunity to be perceived accurately in regards to gender changes the life trajectory of adolescents and young adults. When I began doing this work in 2006, I considered it a victory for transgender adolescents to finish high school. Currently I witness my patients being able to go to college, graduate school, learn trades, become doctors, lawyers, filmmakers, artists, get married, raise families and many other things. This shift directly correlates with access to early gender affirming care, as gender dysphoria takes up an enormous amount of energy that prevents adolescents from performing the tasks required of all adolescents. If gender dysphoria gets addressed early, adolescents and young adults can carry on with the tasks of school, family, relationships, friendships and others. Prior to accessing gender affirming care, many young people with gender dysphoria can't imagine their futures, and many actively try to end their own lives.

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different steps in gender reassignment therapy on psychopathology: a prospective study of persons with a gender identity disorder. *The journal of sexual medicine*, *11*(1), 119–126; Keo-Meier, C. L., et al. (2015). Testosterone treatment and MMPI-2 improvement in transgender men: a prospective controlled study. *Journal of consulting and clinical psychology*, *83*(1), 143–156; Manieri, C., et al. (2014) Medical Treatment of Subjects with Gender Identity Disorder: The Experience in an Italian Public Health Center, *International Journal of Transgenderism*, 15:2, 53-65; Motta, G., et al. (2018). Does Testosterone Treatment Increase Anger Expression in a Population of Transgender Men? *The journal of sexual medicine*, *15*(1), 94–101; Oda, H., & Kinoshita, T. (2017). Efficacy of hormonal and mental treatments with MMPI in FtM individuals: cross-sectional and longitudinal studies. *BMC psychiatry*, *17*(1), 256; and Turan, Ş., et al. (2018). Alterations in Body Uneasiness, Eating Attitudes, and Psychopathology Before and After Cross-Sex Hormonal Treatment in Patients with Female-to-Male Gender Dysphoria. *Archives of sexual behavior*, *47*(8), 2349–2361.

62. As is the case for all medical interventions for minors, before the initiation of puberty blockers and GAH commences following the process of informed consent. Youth and their parent(s) or legal guardian are given information about the permanent changes as well as those that require ongoing use of hormones, potential side effects and what is known and unknown about each medication. Youth and family members have the opportunity to ask and get answers to questions. Parents must consent before treatment is provided.

3) Gender-Affirming Surgeries

63. Some transgender individuals need surgical interventions to help bring their phenotype into alignment with their gender. For youth with gender dysphoria under the age of 18, the most common gender-affirming surgery would be masculinizing chest surgery. While the WPATH SOC 8 do not preclude genital surgery based on a patient's age, it is extraordinarily rare that a minor would undergo genital surgery. As with puberty blockers and gender-affirming hormones, surgery performed on minors requires informed consent from the parent(s) or legal guardian of the youth, as well as assent from the youth.

64. Peer-reviewed research has shown improvements in mental health following gender-affirming chest surgery for transgender males with gender dysphoria where medically indicated.[26]

[26] *See*, *e.g.*, Ascha, M., Sasson, D. C., Sood, R., Cornelius, J. W., Schauer, J. M., Runge, A., Muldoon, A. L., Gangopadhyay, N., Simons, L., Chen, D., Corcoran, J. F., & Jordan, S. W. (2022). Top Surgery and Chest Dysphoria Among Transmasculine and Nonbinary Adolescents and Young Adults. *JAMA Pediatrics*, *176*(11), 1115–1122; Sood, R., Chen, D., Muldoon, A. L., Chen, L., Kwasny, M. J., Simons, L. K., Gangopadhyay, N., Corcoran, J. F., & Jordan, S. W. (2021). Association of Chest Dysphoria With Anxiety and Depression in Transmasculine and Nonbinary Adolescents Seeking Gender-Affirming Care. *The Journal of Adolescent Health*, *68*(6), 1135–1141; Mehringer, J. E., et al. (2021). Experience of Chest Dysphoria and Masculinizing Chest Surgery in Transmasculine Youth. *Pediatrics*, *147*(3), e2020013300; Olson-Kennedy, J., et al. (2018). Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts. *JAMA Pediatrics*, *172*(5), 431–436.

65. A recent systematic review that included data from 1,052 transmasculine patients who obtained chest surgery found that pooled overall postoperative satisfaction was 92%,[27] while another recent study that examined 209 adolescents who had undergone gender-affirming chest surgery between 2013 and 2020 found an extremely low rate of post-operative regret (0.95%).[28]

66. This is consistent with decades of research confirming that gender confirmation surgery is therapeutic and therefore an effective treatment for gender dysphoria.[29]

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67. Recognizing the importance of individualized care, the WPATH SOC-8 has this to say about all gender-affirming medical interventions: "The SOC-8 guidelines are intended to be flexible to meet the diverse health care needs of TGD people globally. While adaptable, they offer standards for promoting optimal health care and for guiding treatment of people experiencing gender incongruence. As in all previous versions of the SOC, the criteria put forth in this document for gender-affirming interventions are clinical guidelines; individual health care professionals and programs may modify them in consultation with the TGD person. Clinical departures from the

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[27] Bustos, V. P., Bustos, S. S., Mascaro, A., Del Corral, G., Forte, A. J., Ciudad, P., Kim, E. A., Langstein, H. N., & Manrique, O. J. (2021). Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence. *Plastic and reconstructive surgery. Global open*, *9*(3), e3477.

[28] Tang, A., Hojilla, J. C., Jackson, J. E., Rothenberg, K. A., Gologorsky, R. C., Stram, D. A., ... & Yokoo, K. M. (2022). Gender-affirming mastectomy trends and surgical outcomes in adolescents. *Annals of Plastic Surgery*, *88*(4), S325-S331.

[29] *See*, *e.g.*, Almazan, A. N., & Keuroghlian, A. S. (2021). Association Between Gender-Affirming Surgeries and Mental Health Outcomes. *JAMA surgery*, 156(7), 611–618; Almazan, et al. (2021); Murad, M. H., et al. (2010). Hormonal therapy and sex reassignment: A systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology*, 72(2), 214-231; Smith, Y., et al. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine* 35(1): 89-99; and Pfafflin, F., & Junge, A. (1998). Sex reassignment: Thirty years of international follow-up studies after sex reassignment surgery, a comprehensive review, 1961-1991.

SOC may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health care professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies. These departures should be recognized as such, explained to the patient, and documented for quality patient care and legal protection."

68. Gender-affirming medical interventions are considered medically necessary for many adolescents with gender dysphoria and are recognized as such by the major professional organizations.

69. There are no evidence-based interventions, other than gender-affirming medical care, to treat gender dysphoria for those who need it.

70. I am familiar with the practices of many gender-affirming care medical providers across the country based on my professional interactions with them through research including our NIH-funded multisite study, professional collaborations, and conferences. Providers across the country, including in Texas, report having observed the same positive outcomes for their patients with gender dysphoria as a result of gender-affirming medical interventions that I have outlined in this declaration and have observed in my over 17 years providing this care.

71. Under SB 14, medical providers would be left with no evidence-based treatment approaches to support their adolescent patients with gender dysphoria. This denial of necessary and effective care will thus result in negative health consequences for transgender adolescents in Texas.

CONCLUSION

72. Gender-affirming medical and surgical care is effective, beneficial, and necessary for transgender people suffering with gender dysphoria, including transgender youth after the onset

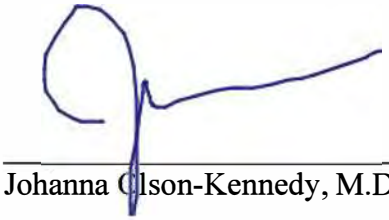
of puberty. It is well documented and studied, through years of clinical experience, observational scientific studies, and even some longitudinal studies. It is also the accepted standard of care by all major medical organizations in the United States.

73. The denial of gender-affirming care, on the other hand, is harmful to transgender people. It exacerbates their dysphoria and may cause anxiety, depression, and suicidality, among other harms.

74. The denial of much needed care only serves to harm transgender people.

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

Executed this 10th day of July 2023.



Johanna Olson-Kennedy, M.D., M.S.

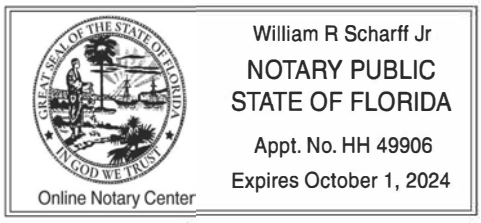
JURAT

State of Florida)
)
County of Pasco)

Before me, a notary public, on this day personally appeared, Johanna Olson-Kennedy, M.D., M.S., known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the foregoing instrument, and being first duly sworn by me states that the statements contained in the foregoing are true and correct to the best of his knowledge, information, and belief.

Sworn to and subscribed before me on the 10th day of July 2023, by Johanna Olson-Kennedy, M.D., M.S.

IN TESTIMONY WHEREOF, I have set my hand and affixed my official seal on the day and year first written above.



William R Scharff Jr
Notary Public
William R Scharff Jr

Notarial Act performed by Audio-Video Communication

EXHIBIT A

Curriculum vitae

CURRICULUM VITAE
JOHANNA OLSON-KENNEDY MS, MD
JUNE 28, 2023

PERSONAL INFORMATION:

Work
4650 Sunset Blvd. MS 2 Los Angeles, CA 90027
Phone: 323-361-3128
Fax: 323-953-8116
Work Email: jolson@chla.usc.edu

EDUCATION AND PROFESSIONAL APPOINTMENTS

EDUCATION:

Year	*Degree, Field, Institution, City*
1992	BA, Mammalian Physiology, UC San Diego, San Diego
1993	MS, Animal Physiology, The Chicago Medical School, Chicago
1997	MD, Medical Doctor, The Chicago Medical Shool, Chicago
2015	MS, Clinical and Biomedical Investigations in Translational Science, USC, Los Angeles

POST-GRADUATE TRAINING:

Year-Year	*Training Type, Field, Mentor, Department, Institution, City*
1997 - 1998	Internship, Pediatrics, Children's Hospital Orange County, Orange
1998 - 2000	Residency, Pediatrics, Antonio Arrieta, Children's Hosptial Orange County, Orange
2000 - 2003	Fellowship, Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles
2012 - 2015	Master's Degree, Clinical and Biomedical Investigations in Translational Science, USC

ACADEMIC APPOINTMENTS:

Year-Year	*Appointment*	*Department, Institution, City, Country*
2006 - 2016	Assistant Professor of Clinical Pediatrics	Division of Adolescent Medicine, Children's Hospital Los Angeles/USC Keck School of Medicine, Los Angeles, USA
2016 - Present	Associate Professor of Clinical Pediatrics	Division of Adolescent Medicine, Children's Hospital Los Angeles/USC Keck School of Medicine, Los Angeles, USA

CLINICAL/ADMINISTRATIVE APPOINTMENTS:

2008 - 2012	Fellowship Director	Division of Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles, USA
2012 - present	Medical Director	The Center for Transyouth Health and Development, Division of Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles, USA

2021 - present	Clinical consultant	Santa Barbara Neighborhood Clinics

LICENSURE, CERTIFICATIONS

LICENSURE:

Year	*License number, State, Status*
2000	A-67352, California, Active

BOARD CERTIFICATION OR ELIGIBILITY:

Year	*Board, State, Status*
2001, 2009, 2015	Pediatrics, California, active

SPECIALTY CERTIFICATION:

Year	*Specialty Certification, Status*
2003, 2013	Adolescent Medicine, California, active

HONORS, AWARDS:

Year	*Description*	*Awarding agency, address, city*
2009	Health Care Advocacy Champion	Democratic Advocates for Disability Issues, Los Angeles
2010	Clinical Research Academic Career Development Award	Saban Research Center TSRI Program: Community Health Outcomes and Intervention, Los Angeles
2012	Extraordinary Service Award	Equality California, 202 W 1st St., Suite 3-0130, Los Angeles
2013	Top Doctor	Castle Connolly
2014	Anne Marie Staas Ally Award	Stonewall Democratic Club; 1049 Havenhurst Drive #325, West Hollywood
2014	Top Doctor	Castle Connolly
2014	Recognition Award for Outstanding, Compassionate and Innovative Service	SoCal Society for Adolescent Health and Medicine Regional Chapter, Los Angeles
2015	The Champion Award	The Division of Adolescent Medicine; CHAMPION FUND 5000 Sunset Blvd. Los Angeles
2016	America's Most Honored Professional's – Top 10%	America's Most Honored Professional's
2016	Regional Top Doctor	Castle Connolly
2017	Exceptional Women in Medicine	Castle Connolly
2017	Regional Top Doctor	Castle Connolly
2017	America's Most Honored Professional's – Top 5%	America's Most Honored Professional's
2018	Regional Top Doctor	Castle Connolly
2019	Benjamin Meaker Visiting Professorship	University of Bristol, Bristol UK
2019	Regional Top Doctor	Castle Connolly
2019	L.A's Top Docs	Los Angeles Magazine
2019	Top Docs	Pasadena Health
2019	America's Most Honored Professional's – Top 1%	America's Most Honored Professional's
2020	Regional Top Doctor	Castle Connolly
2020	Southern California Top Doc	Castle Connolly

2020	Southern California Top Doctors	
2020	L.A's Top Docs	Los Angeles Magazine
2020	America's Most Honored Professional's – Top 1%	America's Most Honored
2021	Southern California Top Doc	Castle Connolly
2021	America's Most Honored Doctors – Top 1%	America's Most Honored
2021	Top Doctors	Castle Connolly
2022	America's Most Honored Doctors – Top 1%	America's Most Honored
2022	Top Doctors	Castle Connolly

TEACHING

DIDACTIC TEACHING:

Keck School of Medicine at USC

Year-Year	*Course Name*	*Units/Hrs*	*Role*
2019	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth	One hour	Curriculum development and delivery
2020, 2021, 2022	Approach to the Care of Gender Non-conforming Children and Transgender Youth	One hour	Curriculum development and delivery
2023	Transgender and Non-binary Youth and Young Adults 101	One hour	Curriculum development and delivery

CalState Fullerton

Year-Year	*Course Name*	*Units/Hrs*	*Role*
2017	Gender Nonconforming and Transgender Youth	One hour	Curriculum development and delivery

UNDERADUATE, GRADUATE AND MEDICAL STUDENT (OR OTHER) MENTORSHIP:

Year-Year	*Trainee Name*	*Trainee Type*	*Dissertation/Thesis/Project Title*
2015 - 2016	David Lyons	MD	Transgender Youth Clinical Clerkship
2016 - 2019	Jonathan Warus	MD	Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts
2019 - 2021	Laer Streeter	MD	Comparison of Histrelin Implants
2020 - Present	Richard Mateo Mora	MD	Fertility Preservation Among Transgender Women
2022	Avery Everhart	PhD	Incomplete Data & Insufficient Methods: Transgender Population Health Research in the US

GRADUATE STUDENT THESIS, EXAM AND DISSERTATION COMMITTEES:

Year-Year	*Trainee Name*	*Committee Type*	*Student Department*
2022	Avery Everhart	Dissertation	Social Work

POSTGRADUATE MENTORSHIP:

Year-Year	*Trainee Name*	*If past trainee, current position and location*
2012-2013	Lisa Simons, MD	Clinical Instructor – Lurie Children's Hospital
2013	Shelley Aggarwal, MD	Clinical Instructor – Stanford University School of Medicine
2014	Julie Spencer, MD	Adolescent Medicine Provider Kaiser Hospital
2014-2015	Michael Haymer, MD	Program Director, Psychiatry Department UCLA
2015-2017	Patrick Shepherd, MD	CHLA Endocrinology Fellow
2015-2018	Jonathan Warus, MD	Faculty, CHLA/USC Keck School of Medicine
2015-2020	Shannon Dunlap, PhD	Postdoctoral Scholar - Research Associate, University of Southern California, Suzanne Dworak-Peck School of Social Work
2020-Present	Marianela Gomez-Rincon, MD	Adolescent Medicine Fellow
2020-Present	Jonathan Warus, MD	CHLA, Assistant Professor of Clinical Pediatrics
2022	Emmett Henderson, PhD, MS	USC Suzanne Dworak-Peck School of Social Work Senior mentor K99; USC

MENTORSHIP OF FACULTY:

Year-Year	*Mentee Name*	*Mentee Department*
2021 - present	Jonathan Warus, MD	Division of Adolescent Medicine, CHLA
2022 - present	Brigid Conn, PhD	Clinical Psychologist, CHLA

SERVICE

DEPARTMENT SERVICE:

Year-Year	*Position, Committee*	*Organization/Institution*
2010-2015	Secretary, The CHAMPION Fund Executive Board	The Division of Adolescent Medicine, Children's Hospital Los Angeles

HOSPITAL OR MEDICAL GROUP SERVICE:

Year-Year	*Position, Committee*	*Organization/Institution*
2021 - present	Committee Member	SOGI work group, CHLA

PROFESSIONAL SERVICE:

Year-Year	*Position, Committee*	*Organization/Institution*
2012-present	Member, LGBT Special Interest Group	Society for Adolescent Health and Medicine
2022	Secretary, Executive Board of Directors	US Professional Association of Transgender Health
2016-present		

CONSULTANTSHIPS AND ADVISORY BOARDS:

Year	*Position, Board*	*Organization/Hospital/School, Institution*
2010-2017	Member, Advisory Board	Transyouth Family Allies
2017-present	Member, National Medical Committee	Planned Parenthood
2017 - Present	Board Member	US Professional Association of Transgender Health
2021	Expert Panelist	Robert Wood Johnson Foundation - National Commission on Data Transformation for Health Equity
2021	Member, Advisory Board	The National LGBTQIA+ Health Education Center
2023	Working Group Member; Expanding the Evidence Base in Gender-Affirming Care for Transgender and Gender Diverse Populations	NIH, Sexual & Gender Minority Research Office
2023	Consultant	Behavioral Health Excellence-Technical Assistance Center funded by the Health Resources and Services Administration (HRSA) to provide technical assistance, training, resources, tools, and consultation to their BHWET (Behavioral Health Workforce Education and Training), OWEP (Opioid Workforce Expansion Program) and GPE (Graduate Psychology Education) grantees.

PROFESSIONAL SOCIETY MEMBERSHIPS:

Year- Year	*Society*
2003 - present	Society for Adolescent Health and Medicine
2005 - present	American Academy of Pediatrics
2006 - 2011	Los Angeles Pediatric Society (Past president 2010)
2010 - present	Professional Association for Transgender Health
2014 - present	Society for Pediatric Research
2017 - present	US Professional Association for Transgender Health

MAJOR LEADERSHIP POSITIONS: (E.G., DEAN, CHAIR, INSTITUTE DIRECTOR, HOSPITAL ADMINISTRATION, ETC.)

RESEARCH AND SCHOLARSHIP

EDITORSHIPS AND EDITORIAL BOARDS:

Year-Year	*Position*	*Journal/Board Name*
2015 - present	Associate Editor	Journal of Transgender Health

MANUSCRIPT REVIEW:

Year-Year	*Journal*
2014 - present	Pediatrics
2014 - present	Journal of Adolescent Health
2014 - present	LGBT Health
2014 - present	International Journal of Transgenderism
2015 - present	Journal of Transgender Health
2018 - present	Clinical Child Psychology and Psychiatry
2018 - present	Journal of Sexual Medicine
2021 - present	JAMA Peds

GRANT REVIEWS:

Year	*Description*	*Awarding agency, City, State, Country*
2017	Cognition and Perception Study Section	National Institutes of Health, Bethesda, Maryland, USA
2017	Neurological, Aging and Musculoskeletal Epidemiology Study Section	National Institutes of Health, Bethesda, Maryland, USA
2018	Social Psychology, Personality and Interpersonal Processes Study Section	National Institutes of Health, Bethesda, Maryland, USA
2018	Neurological, Aging and Musculoskeletal Epidemiology Study Section	National Institutes of Health, Bethesda, Maryland, USA
2019	Special Emphasis Panel Review of Research Conference (R13) Grants	National Institutes of Health, Bethesda, Maryland, USA
2019	The Einstein Foundation Award for Promoting Quality in Research	Einstein Foundation, Berlin
2020	Biobehavioral and Behavioral Sciences Study Section	National Institutes of Health, Bethesda, Maryland, USA
2021	Social Psychology, Personality and Interpersonal Processes Study Section	National Institutes of Health, Bethesda, Maryland, USA

MAJOR AREAS OF RESEARCH INTEREST

Research Areas
1. Transgender and non-binary children, adolescents and young adults
2. HIV medication adherence

GRANT SUPPORT - CURRENT:

Grant No. (PI)2R01HD082554-06A1 (Olson-Kennedy)	*Dates of Award: 2021-2026*
Agency: NICHD	*Percent Effort 25%*
Title: The Impact of Early Medical Treatment in Transgender Youth	
Description: This is the continuations of a multicenter study, the first of its kind in the U.S. to evaluate the long-term outcomes of medical treatment for transgender youth. This study will provide essential, evidence-based information on the physiological and psychosocial impact, as well as safety, of hormone blockers and cross-sex hormones use in this population.	

Role: Principle Investigator
*Total Direct Costs: $*4,918,586

Grant No. 1R01HD097122-01 (Hidalgo)	*Dates of Award: 2019-2024*
Agency: NICHD	*Percent Effort 2.5%*
Title: A Longitudinal Study of Gender Nonconformity in Prepubescent Children	
Description: The purpose of this study is to establish a national cohort of prepubertal transgender/gender nonconforming (TGNC) children (and their parents), and longitudinally observe this cohort to expand the body of empirical knowledge pertaining to gender development and cognition in TGNC children, their mental health symptomology and functioning over time, and how family-initiated social gender transition may predict or alleviate mental health symptoms and/or diagnoses.	
Role: Site PI	
Total Direct Costs: $2,884,950	

Grant No. LGBT Health Equity	*Dates of Award: 2023-2025*
Agency: California Department of Public Health	*Percent Effort 10%*
Title: Beliefs, Knowledge, and Attitudes of Pediatric Primary Care Providers Serving Latine Communities Regarding Gender-Affirming Care for Minors	
Description: This study aims to better understand the current barriers facing Latine pubertal TGNB youth and their parents/caretakers in accessing gender affirming care, assess the attitudes, beliefs, knowledge, perspectives, and comfort level of pediatric primary care providers serving people in predominately Latine communities regarding TGNB youth.	
Role: Principle Investigator	
Total Direct Costs: $237,857	

GRANT SUPPORT - PAST:

Grant No. (PI) 1RO1HD082554-01A1	*Dates of Award: 2015-2020*
Agency: NICHD	*Percent Effort 45%*
Title: The Impact of Early Medical Treatment in Transgender Youth	
Description: This is a multicenter study, the first of its kind in the U.S. to evaluate the long-term outcomes of medical treatment for transgender youth. This study will provide essential, evidence-based information on the physiological and psychosocial impact, as well as safety, of hormone blockers and cross-sex hormones use in this population.	
Role: Principle Investigator	
*Total Direct Costs: $*4,631,970	
Grant No. (COI) R01AI128796-01	Dates of Award: 2/24/17-1/31/18
Agency: NIAID	Percent Effort: 5%
Title: Maturation, Infectibility and Trauma Contributes to HIV Susceptibility in Adolescents	

Description: This proposal explores the overarching hypothesis that fluctuations in sex steroid levels and mucosal trauma (sexual activity) are key determinants of mucosal immune activation and epithelial integrity, and that microbial communities are central to these processes. We will pursue this hypothesis by examining longitudinal changes in the anogenital microbiome as well as protein expression at these mucosal sites during sexual maturation (cisgender youth) and in hormonally-controlled sexual maturation (transgender youth). Associations between sex steroid levels, microbial community composition, mucosal trauma, and vaginal proteins will be determined and modeled.
Role: Co-Investigator
Total Direct Costs: $44,816

Grant No. (PI) U01HD040463	*Dates of Award* 2006 – 2016
Agency: NIH/NICHD	*Percent Effort: 10%*
Title: Adolescent Medicine Trials Network for HIV/AIDS	
Description: Adolescent Medicine Trials Network for HIV/AIDS	
Role: Co-Investigator	
Total Direct Costs: 2,225,674	

Grant No. (PI) SC CTSI 8KL2TR000131	*Dates of Award: 2012-2014*
Agency: KL2 Mentored Career Research Development Program of the Center for Education, Training and Career Development	*Percent Effort: 37.5%*
Title: The Impact of Hormone Blockers on the Physiologic and Psychosocial Development of Gender Non-Conforming Peri-Pubertal Youth	
Description: This study aimed to understand the impact of puberty blocking medications on mental health and physiolgic parameters in peri-pubertal transgender youth.	
Role: Principal Investigator	
Total Direct Costs: 191,525	

Invited Lectures, Symposia, keynote addresses

Date	***Type***	***Title, Location***
2014	Invited Lecture	Transgender Youth; Needs, Risks, Outcomes and the Role of the System, Including Permanency and Inclusion for Our Youth, Administrative Office of the Courts, Center for Families and Children, San Diego, California
2015	Invited Lecture	Caring for Gender Non-Conforming and Transgender Youth, Lopez Family Foundation Special Lecture for Puerto Rico and Panama, Lopez Family Foundation, Children's Hospital Los Angeles, Los Angeles, California
2015	Symposium	Transgender Youth – An Overview of Medical and Mental Health Needs of Gender Non-Conforming Children and Transgender Adolescents, Public Child Welfare Training Academy, Academy for Professional Excellence at San Diego State University School of Social Work, San Diego, California
2015	Invited Lecture	Meeting the Needs of Transgender Adolescents; 1st Annual Southern California LGBT Health Symposium; USC/UCLA, Los Angeles, California

2015	Symposium	Transgender Youth; An Overview of Medical and Mental Health Needs of Gender Non-conforming Children and Transgender Adolescents; GetReal California's Initiative; "Integrating Sexual Orientation, Gender Identity, and Expression (SOGIE) into California's Child Welfare System," Oakland, California
2016	Invited Symposium	Caring for Gender Nonconforming and Transgender Youth; Idyllwild, California
2016	Educational symposium	Gender 101: A Primer; Vista Mar, California
2016	Invited Lecture	Caring for Gender Non-conforming Children and Teens in the New Millennium - A Multidisciplinary Team Approach, California Association of Marriage and Family Therapists, Los Angeles, California
2016	Invited Lecture	Caring for Gender Nonconforming Children and Transgender Youth, California Psychological Association, Continuing Education Institute, Irvine, California
2016	Invited Lecture	Health Issues Related to Transgender Youth; LA City Health Commission, Los Angeles, California
2016	Invited Lecture	Caring for Gender Nonconforming and Transgender Youth, Medical Directors 12th Annual Update on Reproductive Health and Medical Leadership, Planned Parenthood, Steamboat Springs, Colorado
2016	Invited Lecture	Caring For Transgender Teens, UCLA Meet the Professor, Los Angeles, CA
2017	Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Santa Barbara, CA
2017	Invited Lecture	Healthcare for TGNC Youth, Expanding Competency for LGBT Youth in the System Conference, Center for Juvenile Justice Reform, Washington DC
2017	Invited Lecture	Gender Non-conforming and Transgender Children and Youth; Center for Early Education, West Hollywood, CA
2017	Invited Lecture	Gender Non-Conforming Children and Transgender Youth, Board of Behavioral Sciences, Orange, CA
2017	Invited Lecture	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth, Santa Monica Rape Treatment Center, Santa Monica, CA
2017	Invited Lecture	Transgender Youth Care in the New Millennium, USC Law and Global Health Initiative, Los Angeles, CA
2018	Invited Lecture	Supporting Gender Diverse and Transgender Youth: A Deeper Look at Gender Dysphoria, Invited lecture, Oakwood School, Studio City, California, 2018
2018	Invited Lecture	Working with Trans and Gender Non-Conforming Youth, Children's Hospital Orange County, CA
2018	Invited Lecture	Caring for gender Non-conforming and Transgender Youth and Young Adults, Ascend Residential, Encino CA
2018	Invited Lecture	Caring for gender Non-conforming and Transgender Youth and Young Adults, California State University Northridge, Northridge, CA
2018	Invited Lecture	Gender Dysphoria; School Nurse Association of Idaho Annual Conference, School Nurse Association of Idaho Association, Boise Idaho
2018	Invited Lecture	Gender and What You Should Know, Archer School for Girls, Brentwood, CA
2018	Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Oceanside, CA
2018	Invited Lecture	Gender Dysphoria: Beyond the Diagnosis, Advance LA Thriving Through Transitions Conference, The Help Group, Los Angeles, California

2018	Invited Lecture	Caring for Gender Non-Conforming and Transgender Youth, Andrology Society of America Clinical Symposium, Andrology Society of America, Portland, Oregon
2018	Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Los Angeles, CA
2018	Invited Lecture	Caring for Gender Non-Conforming and Transgender Youth, Center for Early Education, Los Angeles, CA
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Cal State Los Angeles, California
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Claremont Colleges, California
2019	Symposium	TransYouth Care; Flagstaff, AZ
2019	Invited Lecture	Transgender and Gender Non-conforming Youth, Invited lecture, Elevations Residential Treatment, Salt Lake City, Utah
2019	Invited Lecture	Gender Diverse and Transgender Youth; What Pediatricians Should Know, Common Problems in Pediatrics Conference, Utah AAP, Utah
2019	Invited Lecture	Caring for Gender Diverse and Transgender Youth, Grand Rounds, UCLA Olive View, CA
2019	Invited Lecture	Caring for Gender Diverse and Transgender Youth, Grand Rounds, Good Samaritan, Los Angeles, California
2019	Invited Lecture	Puberty Suppression in Youth with Gender Dysphoria, Fenway Trans Health Program, Boston
2019	Invited Lecture	Recognizing the Needs of Transgender Youth, California Department of Corrections and Rehabilitation, Ventura, CA
2019	Invited Lecture	Gender Dysphoria; Beyond the Diagnosis, Gender Education Demystification Symposium, Gender Education and Demystification, Atlanta, Georgia
2019	Invited Lecture	Caring for Gender Nonconforming and Transgender Youth, Los Angeles Superior Court/Los Angeles Bar Association Training, CA
2019	Invited Lecture	Supporting Gender Diverse and Transgender Youth; A Deeper Look at Gender Dysphoria, Oakwood School, CA
2020	Symposium	Trans Youth Care, Chico Transgender Week, Virtual Presentation
2020	Invited Lecture	Gender Nonconforming and Transgender Youth, Novartis, Virtual Presentation
2020	Invited Lecture	Advanced Hormones; More than Just T and E, CHLA, Virtual Presentation
2020	Invited Lecture	Video Telehealth and Transgender Youth, Telehealth Best Practices for the Trans Community, The Central Texas Transgender Health Coalition, Virtual Presentation
2020	Invited Lecture	Gear Talk, Transforming Families, Virtual Lecture
2020	Invited Lecture	Tips for Parenting a Trans or Gender Diverse Youth, Models of Pride, Virtual Presentation
2020	Invited Lecture	Caring for Gender Diverse and Transgender Youth, LGBTQ+ Clinical Academy, Palo Alto University, Virtual presentation
2020	Invited Lecture	Medical Interventions for transgender youth, Cal State Los Angeles, Los Angeles
2020	Plenary Session	Understanding Issues Involving Gender Non-Conforming and Transgender Individuals Coming to a Courtroom Near You, Mid-Winter Workshop for Judges of the Ninth Circuit, Palm Springs, CA

2021	Invited Lecture	Gender Affirmation through a Social Justice Lens; Center for Gender Equity in Medicine and Science (GEMS) at Keck School of Medicine, Los Angeles
2021	Invited Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Providence Medical Group – South Bay Pediatrics (Torrance, San Pedro, Redondo Beach), virtual lecture
2021	Invited Lecture	Caring for Gender Diverse and Transgender Youth. San Luis Obispo Acceptance, Cal Poly, Virtual Presentation
2022	Invited Lecture	Transgender and Non-binary children and youth, Board of Behavioral Sciences
2022	Invited Lecture	Gender Affirmation through a Social Justice Lens; University of Arizona Health Sciences LGBTQ+ Symposium & Health Fair
2022	Invited Lecture	Gender Dysphoria in Children, Adolescents and Young Adults, MedLambda and PsychSIG Keck USC School of Medicine, Virtual Lecture
2022	Invited Lecture	Caring for Transgender and Gender Nonconforming Youth, Presbyterian Healthcare Services, New Mexico, Virtual lecture
2022	Invited Lecture	Transgender and Non-Binary Youth, Rogers Behavioral Health, Virtual Lecture
2023	Invited Lecture	**Transgender and Non-binary Youth and Young Adults 101,** When Healthcare Gets Political; Health Justice and Systems of Care course, Keck USC School of Medicine, Los Angeles
2023	Invited Lecture	Transgender and Non-Binary Youth; Navigating Gender Care in 2023, Improving Outcomes Conference, UC Davis, Sacramento, CA
2023	Invited Lecture	Gender Affirming Medical and Mental Health Care for Transgender Adolescents, California Association of Marriage and Family Therapists Annual Conference, Santa Clara, CA
2023	Invited Lecture	Trans Youth Care in 2023; What's New, What's Not, Behavioral Health Excellence-Technical Assistance Center

Invited Grand Rounds, CME Lectures

Date	***Type***	***Title, Location***
2014	Grand Rounds	Caring for Gender Non-conforming Children and Teens in the New Millennium - A Multidisciplinary Team Approach; Seattle Children's Hospital, Seattle, Washington
2014	CME lecture	Transgender Youth; An Overview of Medical and Mental Health Needs of Gender Non-conforming Children and Transgender Adolescents; Eisenhower Medical Center Transgender Health Symposium, Palm Springs, California
2014	Grand Rounds	Toddlers to Teens: Comprehensive Health Care for the Transgender Child, Cultural Psychiatry Lecture Series, University of Iowa Carver College of Medicine, Iowa City, Iowa
2014	Grand Rounds	Caring for Gender Non-conforming Children and Teens in the New Millennium; A Multidisciplinary Team Approach, Children's Hospital Los Angeles, Los Angeles, California
2014	CME lecture	Difficult Cases, Gender Spectrum Family Conference, Gender Spectrum, Moraga, California
2014	CME lecture	Cross-sex Hormones for Teenagers, How Young is Too Young? Philadelphia Trans Health Conference, Philadelphia, Pennsylvania

2014	CME lecture	Pediatric Update, Philadelphia Trans Health Conference, Philadelphia, Pennsylvania
2015	Grand Rounds	Caring for Gender Nonconforming and Transgender Youth, Stanford Division of Adolescent Medicine, Palo Alto, CA
2015	CME Educational Lecture	Update on the Transgender Patient for the PCP, St. Joseph's Providence, Burbank, CA
2015	CME Educational Lecture	Caring for Gender Non-Conforming Children and Transgender Teens, Providence Tarzana, CA
2015	Grand Rounds	Caring for Gender Nonconforming and Transgender Youth, University of Southern California, Los Angeles, California
2015	Grand Rounds	Puberty Blockers and Cross Sex Hormones, Pediatric Endocrinology, Children's Hospital Los Angeles, Los Angeles, California
2015	CME lecture	Youth and Hormones, 2015 Gender Expansion Conference, University of Montana, Missoula Montana
2015	CME lecture	Transyouth Healthcare, 2015 Gender Expansion Conference, University of Montana, Missoula Montana
2015	CME lecture	Supporting Transgender Youth, Southern Oregon University Student Health and Wellness Center Workshop, Southern Oregon University, Ashland, Oregon
2015	PCS Grand Rounds	Caring for Gender Nonconforming Children and Transgender Youth, Children's Hospital Los Angeles, Los Angeles, California
2015	CME lecture	Medical Care for Gender Non-Conforming Children, Transgender Adolescents and Young Adults in the New Millennium, Continuing Medical Education of Southern Oregon, Medford, Oregon
2015	Grand Rounds	Medical Care for Gender Non-Conforming Children and Transgender Youth, Olive View Medical Center-UCLA, Sylmar, California
2015	Grand Rounds	Caring for Gender Non-conforming Children and Transgender Teens, Harbor-UCLA Department of Pediatrics, Torrance, California
2015	CME lecture	Caring for Gender Non-conforming Children and Teens in the New Millennium, Healthcare Partners Pediatric Town Hall Meeting, Healthcare Partners CME, Glendale, California
2016	Pediatric Grand Rounds	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth; Children's Hospital Los Angeles, Los Angeles, California
2016	Endocrine Grand Rounds	Approach to Care of Gender Non-Conforming Children and Transgender Adolescents; Cedars Sinai Hospital, Los Angeles, California
2016	Pediatric Grand Rounds	Care of Gender Non-Conforming Children and Transgender Adolescents in the New Millennium, Stanford Lucille Packard Children's Hospital, Palo Alto, California
2016	Pediatric Update	Caring for Gender Variant Children and Adolescents, Pediatric Update for the Primary Provider, Children's Hospital St. Louis, St. Louis, Missouri
2016	Grand Rounds	Care of Gender Non-Conforming Children and Transgender Adolescents in the New Millennium, St. Jude's Grand Rounds, Memphis, Tennessee
2016	CME Educational Lecture	Transgender and Gender Non-Conforming Youth: Innovative Approaches to Care in 2016; Integrating Substance Use, Mental Health, and Primary Care Services: Courageous and Compassionate Care, Los Angeles, California

2016	CME; professional conference	Caring for Gender Non-conforming Children and Teens in the New Millennium - A Multidisciplinary Team Approach, Arizona Psychiatric Society, Tempe, Arizona
2016	CME/Educational Symposium	Caring for Gender Nonconforming and Transgender Youth, San Diego, California
2016	CME/CEU Educational Training	Medical Interventions for Transgender Youth and Young Adults, San Diego State University, San Diego, California
2016	Grand Rounds	Caring for Gender Nonconforming Children and Transgender Youth, Mt. Sinai Hospital, Pediatric Grand Rounds George J. Ginandes Lecture, New York, New York
2016	CME Educational Lecture	The Transgender Experience, Providence Tarzana, CA
2017	CME Educational Seminar	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, San Diego, CA
2017	CME Educational Seminar	The Care of Gender Non-Conforming children and Transgender Youth; Orange County Health Care Agency, Orange County, CA
2017	CME Educational Lecture	Rethinking Gender, Adolescent Grand Rounds, Children's Hospital Los Angeles, Los Angeles, CA
2017	CME Educational Lecture	Gender Non-Conforming Children and Transgender Youth, CME lecture for OB/Gyn, Omnia-Prova Education Collaborative, inc. Pasadena, California
2017	CME Educational Lecture	Gender Non-Conforming and Transgender Children and Adolescents, Developmental Pediatrics continuing education lecture, Children's Hospital Los Angeles, CA
2017	CME Educational Lecture	Care of Gender Non-Conforming Children and Transgender Adolescents, Lopez Family Foundation Educational Lecture, Los Angeles, CA
2017	CME Educational Lecture	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth, USC Keck School of Medicine Reproductive Health, Los Angeles, CA
2017	CME Educational Seminar	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, San Diego, CA
2018	CME Symposium	Caring for Gender Nonconforming and Transgender Youth, Glendale Unified School District, CA
2018	CME Educational Lecture	Caring for Gender Non-Conforming Children and Transgender Youth, CME by the Sea, CA
2018	CME Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Austin, TX
2018	CME Educational Lecture	Approach to the Care of Gender Non-Conforming Children and Transgender Youth, Desert Oasis Healthcare, Palm Desert, CA

2018	CME Workshop	Mental and Medical Healthcare for Transgender Adolescents, California Association of Marriage and Family Therapists, Garden Grove, CA
2018	CME Educational Lecture	Approach to the Care of Gender Non-Conforming Children and Transgender Youth, Keck School of Medicine, Los Angeles, CA
2018	Grand Rounds	Caring for Gender Non-Conforming Children and Transgender Adolescents, Primary Children's Hospital, Salt Lake City, UT
2018	CME Educational Lecture	Caring for Transgender Youth, Chico Trans Week, Chico, CA
2018	CME Educational Lecture	Rethinking Gender, UCSD Medical School, San Diego, CA
2018	CME Educational Lecture	Rethinking Gender, UCLA Medical School, Los Angeles, CA
2019	Symposium	Recognizing the Needs of Transgender Youth, California Department of Corrections and Rehabilitation, Stockton, CA
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Cal State Los Angeles, California
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Claremont Colleges, California
2019	CME Lecture	Gender Diverse and Transgender Youth, Harbor UCLA Medical Center Grand Rounds, Torrance, CA
2019	CME Lecture	Gender Dysphoria – Beyond the Diagnosis, Gender Odyssey San Diego, San Diego, CA
2019	Grand Rounds	Transgender Youth; What's New in 2019?, Children's Hospital Los Angeles, CA
2019	CME Symposium	Caring for Gender Nonconforming and Transgender Youth, Children's Hospital Orange County, CA
2019	CME Symposium	Caring for Gender Nonconforming and Transgender Youth, Stanislaus County Behavioral Health and Recovery Services, CA
2019	CME Eduational Lecture	Rethinking Gender, Olive View Medical Center Grand Rounds, CA
2020	CME Lecture	Gender Affirmation Through a Social Justice Lens, SAHM Conference, Virtual Presentation
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, AAP Conference, Virtual Lecture
2020	CME Lecture	Conversations with LGBTQ youth; the role of the pediatrician, AAP Conference, Virtual Lecture
2020	Grand Rounds	Creating Affirming Environments for Trans and Gender Diverse Patients, USC OB/Gyn Grand Rounds, Virtual Presentation
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Resident Lecture, CHLA
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Facey Medical Group, Los Angeles, CA

2020	Plenary Lecture	Reframing Gender Dysphoria, LEAH Conference, Los Angeles, CA
2020	CME Lecture	Gender Affirming Care for Pre and Peri-pubertal Trans and Gender Diverse Youth, LEAH Conference, Los Angeles, CA
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Division of Endocrinology, USC, Los Angeles, CA
2021	CME Lecture	Transitioning from Invalidation and Trauma to Gender Affirming Care; ACCM Grand Rounds, Children's Hospital Los Angeles, Virtual presentation
2021	CME Symposium	TransYouth Care; Transfamily Support San Diego, Virtual Symposium
2021	Symposium	TransYouth Care for Parents; Santa Clara, CA
2022	CME Lecture	Gender affirming medical interventions; An Evolving landscape, Critical Issues in Child and Adolescent Mental Health Conference, San Diego, California
2022	CME Symposium	TransYouth Care for Mental Health Providers; Santa Clara, CA
2022	CME Symposium	TransYouth Care; Transfamily Support San Diego, Virtual Symposium

International Lectures

Date	***Type***	***Title, Location***
2013	Keynote	Caring for Gender Non-conforming Children and Adolescents in the New Millennium, Vancouver, Canada
2016	CME; professional conference	Social Transitions in Pre-pubertal Children; What do we know? World Professional Association of Transgender Health, Amsterdam, The Netherlands
2016	CME; professional conference	Beyond Male and Female; Approach to Youth with Non-Binary Gender Identities, World Professional Association of Transgender Health, Amsterdam, The Netherlands
2016	CME; professional conference	Workgroup on Gender Nonconforming/Transgender Youth: Biopsychosocial Outcomes and Development of Gender Identity, World Professional Association of Transgedner Health, Amsterdam, The Netherlands
2017	Invited Lecture	Gender Dysphoria, Beyond the Diagnosis, Pink Competency, Oslo Norway
2017	Invited Lecture	Caring for Gender Non-Conforming Children and Transgender Adolescents: A United States Perspective, Pink Competency, Oslo Norway
2017	Invited Lecture	Caring for Gender Non-conforming and Transgender youth and Young Adults, Diverse Families Forum: The Importance of Family Support in The Trans And LGBT Children, Organized by COPRED and The

		International Association Of Families For Diversity (FDS), Mexico City, Mexico
2018	Invited Lecture	Chest Reconstruction and Chest Dysphoria in Transmasculine Adolescents and Young Adults: Comparison of Nonsurgical and Postsurgical Cohorts, Buenos Aires, Argentina
2018	Invited Lecture	Transgender Youth and Gender Affirming Hormones; A 6-8 year follow-up, Buenos Aires, Argentina
2018	Invited Lecture	Transyouth Care – An NIH Multisite Study About the Impact of Early Medical Treatment in Transgender Youth in the US, Buenos Aires, Argentina
2018	Invited Lecture	Uso de Hormonas Reaffirmantes de Genero en Adolescentes Transgenero, Trans Amor Congreso Nacional de Transexualidad Juvenil y Infantos, Monterey, Mexico
2018	Invited Lecture	Bloquedores de la Pubertad, Trans Amor Congreso Nacional de Transexualidad Juvenil y Infantos, Monterey, Mexico
2018	CME Educational Lecture	Puberty Blockers and Gender Affirming Hormones for Transgender Youth: What Do We Know, and What Have We Learned, Pediatric Academic Societies, Toronto, Canada
2019	Grand Rounds	Rethinking Gender, Grand Rounds, The Hospital for Sick Children, Toronto, Canada
2019	Keynote	***Gender Dysphoria; Beyond the Diagnosis,*** Promoting Innovation and Collaboration to Support Gender Diverse Youth Conference, The Hospital for Sick Children, Toronto, Canada, December 2019
2019	Invited Lecture	Hormonas que Affirman el Genero pasa Juventud y Adultos Menores Trans, Transformando Desde el Amor y Las Familias, Colombia
2019	Invited Lecture	Infancia Trans y da Genero Diverso, Transformando Desde el Amor y Las Familias, Colombia
2019	Invited Lecture	Transgender Youth: Medical and Mental Health Needs, Bristol, United Kingdom
2019	Invited Lecture	Rethinking Gender, University of Bristol, United Kingdom
2019	CME; professional conference	Male Chest Reconstruction and Chest Dysphoria in Transmasculine Adolescents and Young Adults, European Professional Association of Transgender Health, Rome Italy
2019	CME; professional conference	Transgender Youth and Gender Affirming Hormones; 5-7 Year Follow Up, European Professional Association of Transgender Health, Rome Italy
2019	CME Educational Lecture	Gender Dysphoria; Beyond the Diagnosis, European Professional Association of Transgender Health, Rome Italy
2022	Plenary Session	The Landscape of Gender Affirming Care for Youth in the US, AusPATH, Virtual
2022	CME; professional conference	Emotional Functioning of Adolescents with Gender Dysphoria After Two Years of Treatment; WPATH Conference, Montreal, Canada

2022	CME; Professional Conference	Creating Enduring Materials; WPATH Conference, Montreal, Canada

Keynote/Plenary Presentations

Date	***Type***	***Title, Location***
2015	Keynote	The Future of Trans Care in the New Millennium, Gender Infinity Conference, Houston, Texas
2016	Plenary Session	Caring for Trans Youth and Gender Non-Conforming Children, Transgender Spectrum Conference, St. Louis, Missouri
2017	Invited Lecture	Rethinking Gender, Keynote, Annual Convocation Welcome Luncheon for the LGBTA Community, University of Massachusetts, Worcester, Massachusetts, 2017
2018	Keynote	Future Directions, USPATH, Washington DC
2019	Keynote	Gender Dysphoria; A Deeper Dive Beyond the Diagnosis, Inaugural LGBTQ summit, Santa Clara CA
2021	CME; professional conference	Advances and Challenges in the Care of Transgender/Gender Diverse Youth; USPATH Conference, Virtual presentation
2022	Keynote	Gender Affirmation Through a Social Justice Lens, Indiana University School of Medicine
2022	Invited Lecture	Transgender and Non-Binary Youth, Supporting the Well-Being of LGBTQ Youth Certificate Program Center for Juvenile Justice Reform Georgetown University, virtual training
2022	Invited Lecture	Transgender and Non-Binary Youth, Young Women's Career Conference (YWCC) for the Girls Academic Leadership Academy; virtual lecture

PUBLICATIONS:

*** INDICATES TRAINEES**
**** INDICATE YOURSELF AS CO-FIRST OR CO-CORRESPONDING OR SENIOR AUTHORS**

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1. Belzer M, Sanchez K, **Olson J**, Jacobs AM, Tucker D. Advance supply of emergency contraception: a randomized trial in adolescent mothers. J Pediatr Adolesc Gynecol. 2005 Oct;18(5):347-54. PubMed PMID: 16202939.

2. Puccio JA, Belzer M, **Olson J**, Martinez M, Salata C, Tucker D, Tanaka D. The use of cell phone reminder calls for assisting HIV-infected adolescents and young adults to adhere to highly active antiretroviral therapy: a pilot study. AIDS Patient Care STDS. 2006 Jun;20(6):438-44. PubMed PMID: 16789857.

3. **Olson J**,** Forbes C, Belzer M. Management of the transgender adolescent. Arch Pediatr Adolesc Med. 2011 Feb;165(2):171-6. doi: 10.1001/archpediatrics.2010.275. Review. PubMed PMID: 21300658.

4. Simons L*, Schrager SM, Clark LF, Belzer M, **Olson J**.** Parental support and mental health among transgender adolescents. J Adolesc Health. 2013 Dec;53(6):791-3. DOI: 10.1016/j.jadohealth.2013.07.019. Epub 2013 Sep 4. PubMed PMID: 24012067; PubMed Central PMCID: PMC3838484.

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6. **Olson J****, Garofalo R. The peripubertal gender-dysphoric child: puberty suppression and treatment paradigms. Pediatr Ann. 2014 Jun;43(6):e132-7. doi: 10.3928/00904481-20140522-08. PMID: 24972421.

7. **Olson J****, Schrager SM, Clark LF, Dunlap SL, Belzer M. Subcutaneous Testosterone: An Effective Delivery Mechanism for Masculinizing Young Transgender Men. LGBT Health. 2014 Sep;1(3):165-7. doi: 10.1089/lgbt.2014.0018. Epub 2014 Jun 26. PMID: 26789709.

8. Schrager SM, **Olson J,** Beharry M*, Belzer M, Goldsich K*, Desai M, Clark LF. Young men and the morning after: a missed opportunity for emergency contraception provision? J Fam Plann Reprod Health Care. 2015 Jan;41(1):33-7. doi: 10.1136/jfprhc-2013-100617. Epub 2014 Jan 24. PubMed PMID: 24465024.

9. Belzer M, Kolmodin MacDonell K, Clark L, Huang J, **Olson J**, Kahana S, Naar S, Sarr M, Thornton S. Acceptability and Feasibility of a Cell Phone Support Intervention for Youth Living with HIV with Nonadherence to Antiretroviral Therapy, AIDS Patient Care and STDs, Vol. 29, No. 6, June 2015: 338-345. doi: 10.1089/apc.2014.0282; PMID: 25928772

10. Klein DA, Ellzy JA, **Olson J****. Care of a Transgender Adolescent. Am Fam Physician. 2015 Jul 15;92(2):142-8. PMID: 26176373.

11. **Olson J****, Schrager SM, Belzer M, Simons LK*, Clark LF. Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria. J Adolesc Health. 2015 Oct;57(4):374-80. doi: 10.1016/j.jadohealth.2015.04.027. Epub 2015 Jul 21. PMID: 26208863; PMCID: PMC5033041.

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15. Sayegh CS, MacDonell KK, Clark LF, Dowshen NL, Naar S, **Olson-Kennedy J**, van den Berg JJ, Xu J, Belzer M. The Impact of Cell Phone Support on Psychosocial Outcomes for Youth Living with HIV Nonadherent to Antiretroviral Therapy. AIDS Behav. 2018 Oct;22(10):3357-3362. doi: 10.1007/s10461-018-2192d-4. PMID: 29948339; PMCID: PMC6530981.

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19. **Olson-Kennedy J****, Chan YM, Rosenthal S, Hidalgo MA, Chen D, Clark L, Ehrensaft D, Tishelman A, Garofalo R. Creating the Trans Youth Research Network: A Collaborative Research Endeavor. Transgend Health. 2019 Nov 1;4(1):304-312. doi: 10.1089/trgh.2019.0024. PMID: 31701011; PMCID: PMC6830532.

20. Lee JY, Finlayson C, **Olson-Kennedy J**, Garofalo R, Chan YM, Glidden DV, Rosenthal SM. Low Bone Mineral Density in Early Pubertal Transgender/Gender Diverse Youth: Findings from the Trans Youth Care Study. Journal of the Endocrine Society. 2020 September 1;4(9):bvaa065. PMID: 32832823; PMCID: PMC7433770; DOI: 10.1210/jendso/bvaa065

21. Millington K, Schulmeister C, Finlayson C, Grabert R, **Olson-Kennedy J**, Garofalo R, Rosenthal SM, Chan YM. Physiological and Metabolic Characteristics of a Cohort of Transgender and Gender-Diverse Youth in the United States. J Adolesc Health. 2020 Sep;67(3):376-383. doi: 10.1016/j.jadohealth.2020.03.028. Epub 2020 May 14. PMID: 32417098; PMCID: PMC7483238.

22. Pang KC, Notini L, McDougall R, Gillam L, Savulescu J, Wilkinson D, Clark BA, **Olson-Kennedy J**, Telfer MM, Lantos JD. Long-term Puberty Suppression for a Nonbinary Teenager. Pediatrics. 2020 Feb;145(2):e20191606. doi: 10.1542/peds.2019-1606. PMID: 31974217.

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2. Hidalgo M, Ehrensaft E, Tishelman A, Clark LF, Garofalo R, Rosenthal SM, Spack NP, **Olson J**; The Gender Affirmative Model: What We Know and What We Aim to Learn. *Human Development* 1 October 2013; 56 (5): 285–290. https://doi.org/10.1159/000355235

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5. **Olson-Kennedy J**. Mental Health Disparities Among Transgender Youth: Rethinking the Role of Professionals. JAMA Pediatr. 2016 May 1;170(5):423-4. doi: 10.1001/jamapediatrics.2016.0155. PMID: 26998945.

6. Clark BA, Virani A, Ehrensaft D, **Olson-Kennedy J**. Resisting the Post-Truth Era: Maintaining a Commitment to Science and Social Justice in Bioethics. Am J Bioeth. 2019 Jul;19(7):W1-W3. doi: 10.1080/15265161.2019.1618951. PMID: 31237512.

7. **Olson-Kennedy J**.** The Care of Gender Non-Conforming and Transgender Youth. Lavin N, Manual of Endocrinology and Metabolism, 5th Edition, Wolters Kluwer, 2019

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4. **Olson J**, Forcier M, Overview of the management of gender nonconformity in children and adolescents, In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA Role: co-first authored manuscript – drafting and editing.
5. Forcier M, **Olson J**, Overview of gender development and clinical presentation of gender nonconformity in children and adolescents, In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. Role: co-first authored manuscript – drafting and editing.

ABSTRACTS AND PRESENTATIONS:

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2. **Olson J**,** Clark L, Schrager S, Simons L, Belzer M, Baseline Characteristics Of Transgender Youth Naïve To Cross Sex Hormone Therapy, J Adol Health, February 2013 (Vol. 52, Issue 2, Supplement 1, Pages S35-S36, DOI: 10.1016/j.jadohealth.2012.10.086)

3. **Olson J**, Transgender Youth; An Overview of Medical and Mental Health Needs of Gender Non-conforming Children and Transgender Adolescents, Models of Pride, Los Angeles LGBT Center's LifeWorks, Los Angeles, CA, 2014

4. **Olson J**, Transitioning Teens and the Adolescent Experience, Gender Spectrum Family Conference, Gender Spectrum, Moraga, CA, 2014

5. **Olson J**, Outside of the Gender Binary: Defining and Caring for Non-Binary Identified Youth, Gender Spectrum Family Conference, Gender Spectrum, Moraga, CA, 2014

6. **Olson J**, Medical Care of Transgender Adolescents, Cross sex Hormones, Gender Infinity Conference, Houston, TX, 2014

7. **Olson J**, Cross Sex Hormone Therapy for Transgender Teens, Southern Comfort Conference, Atlanta, GA, 2014

8. **Olson J**, Puberty Suppression, Southern Comfort Conference, Atlanta, GA, 2014

9. **Olson J**, Medical Treatment of Gender Nonconforming and Transgender Youth, Chico Trans* Week, Stonewall Alliance & Chico California Association of Marriage and Family Therapists, Chico, CA

10. **Olson J**, Transgender Youth 101, Stonewall LGBT Health Symposium, Los Angeles, CA, 2014

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13. **Olson J**, Cross-sex Hormones for Transgender Youth, Transgender Health and Education Alliance Family Conference, Atlanta, Georgia, 2015

14. **Olson J**, Puberty Suppression in Gender Non-conforming Children, Gender Odyssey Conference, Gender Odyssey, Seattle, WA, 2014

15. **Olson J**, Cross sex Hormones, Gender Odyssey Conference, Gender Odyssey, Seattle, WA, 2014

16. **Olson J**, Just a Boy, Just a Girl, Gender Spectrum, Gender Spectrum Professional Conference, Moraga, California, 2015

17. **Olson J**, Transition for Teens and Young Adults, Gender Infinity Provider and Advocacy Day, Gender Infinity Conference, Houston, TX, 2015

18. **Olson J**, Puberty Blockers and Hormone Therapy, Gender Infinity Conference, Houston, TX, 2015

19. **Olson J**, Just a Boy, Just a Girl; Gender Odyssey Conference, Seattle, WA, 2015

20. **Olson J**, Puberty Blockers and Cross Sex Hormones, Gender Odyssey Conference, Seattle, WA, 2015

21. **Olson J**, Outside of the Binary, Gender Odyssey Conference, Seattle, WA, 2015

22. **Olson J**, Outside of the Gender Binary: Defining and Caring for Non-Binary Identified Youth, Gender Spectrum, Gender Spectrum Family Conference, Moraga, CA, 2015

23. **Olson, J**, Caring for Youth with Gender Dysphoria, Pediatric Academic Societies Annual Meeting, Pediatric Academic Societies, San Diego, California, 2015

24. **Olson-Kennedy J,** Parents of Trans and Gender Fluid Youth, Models of Pride, Los Angeles, CA, 2016

25. **Olson-Kennedy J,** Caring for Gender Nonconforming and Transgender Youth, Intersections in Queer Health, SoCal LGBT Health Conference, Irvine, CA, 2016

26. **Olson-Kennedy J,** Outside of the Binary; Care for Non-Binary Adolescents and Young Adults, US Professional Association of Transgender Health, Los Angeles, CA, 2016

27. **Olson-Kennedy J,** Gender Nonconforming Children and Adolescents, AAP National Conference, San Francisco, California, 2016

28. **Olson-Kennedy J,** Masculinizing Hormone Therapy, Gender Infinity, Houston Texas, 2016

29. **Olson-Kennedy J,** Just a Boy, Just a Girl, Houston, Gender Infinity, Houston Texas, 2016

30. **Olson-Kennedy J,** Puberty Blockers, Houston, Gender Infinity, Houston Texas, 2016

31. **Olson-Kennedy J,** Gender Affirming Hormone Therapy for Adolescents and Young Adults, Gender Infinity, Houston Texas, 2016

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33. **Olson-Kennedy J,** Models of Care & Legal Issues Related to Consent, Gender Infinity, Houston Texas, 2016

34. **Olson-Kennedy J,** Defining and Caring for Non-binary Identified Youth, Gender Infinity, Houston Texas, 2016

35. **Olson-Kennedy J,** Beyond Male and Female; Approach to Youth with Non-Binary Gender Identities; Gender Spectrum, Moraga, California, 2016

36. **Olson-Kennedy J,** Meier, C, TYFA Research: Demographics of a US sample of Two Cohorts of Gender Non-conforming Children, Gender Odyssey, Seattle, WA 2016

37. **Olson-Kennedy J,** Gender Affirming Hormones; Gender Odyssey, Seattle, WA 2016

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41. **Olson-Kennedy J,** Puberty Suppression in the United States; practice models, lessons learned, and unanswered questions, US Professional Association of Transgender Health, Los Angeles, CA 2017

42. **Olson-Kennedy J,** Puberty Suppression in the United States; practice models, lessons learned, and unanswered questions, US Professional Association of Transgender Health, Los Angeles, CA 2017

43. **Olson-Kennedy J,** "Just a Boy, Just a Girl" Gender Infinity, Houston TX 2017

44. **Olson-Kennedy J,** Chest Dysphoria – The Impact of Male Chest Reconstruction, Gender Infinity, Houston TX 2017

45. **Olson-Kennedy J,** Outside of the Binary; Care for Non-Binary Adolescents and Young Adults, Gender Infinity, Houston TX 2017

46. **Olson-Kennedy J,** Puberty Blockers; What, When and How, Gender Infinity, Houston TX 2017

47. **Olson-Kennedy J,** Gender Non-Conforming Children and Transgender Youth; Integrated Care Conference, Los Angeles, CA, 2017

48. **Olson-Kennedy J,** Gender Non-Conforming and Transgender Children and Adolescents; A Multidisciplinary Approach, California Psychiatric Association Annual Conference, Yosemite, CA, 2017

49. **Olson-Kennedy J,** Gender Dysphoria; Beyond the Diagnosis, Models of Pride, Los Angeles, CA

50. **Olson-Kennedy J,** Puberty Delay and Cross Hormones for Trans* Youth, Models of Pride, Los Angeles, CA

51. **Olson-Kennedy J,** Masculinizing Hormones, Central Texas Transgender Health Conference, Austin, TX, 2017

52. **Olson-Kennedy J,** Children, Youth, Families and Hormone Blockers, Central Texas Transgender Health Conference, Austin, TX, 2017

53. **Olson-Kennedy J,** "Just a Boy, Just a Girl" Gender Infinity, Houston TX, 2017

54. **Olson-Kennedy J,** Chest Dysphoria – The Impact of Male Chest Reconstruction, Gender Odyssey Professional Symposium, Seattle, WA, 2017

55. **Olson-Kennedy J,** Puberty Delay and Cross Hormones for Transyouth, Gender Odyssey Professional Symposium, Seattle, WA, 2017

56. **Olson-Kennedy J**, Olson-Kennedy A, Just a Girl, Just a Boy, Gender Odyssey Professional Symposium, Pasadena, CA, 2017

57. **Olson-Kennedy J**, Puberty Blockers and Cross Sex Hormones, Gender Odyssey, Pasadena, CA, 2017

58. **Olson-Kennedy J**, Olson-Kennedy A, Gender Dysphoria, Gender Spectrum Family Conference, Moraga, CA, 2017

59. **Olson-Kennedy J**, Rethinking Gender, Chico TransGNC Week, Chico, CA, 2017

60. **Olson-Kennedy J**, Caring for Gender Non-Conforming and Transgender Youth, Chico TransGNC Week, Chico, CA, 2017

61. **Olson-Kennedy J**, Puberty Suppression in the United States; practice models, lessons learned, and unanswered questions, US Professional Association of Transgender Health, Los Angeles, CA, 2017

62. **Olson-Kennedy J**, The Impact of Male Chest Reconstruction on Chest Dysphoria in Transmasculine Adolescents and Young Men; A Preliminary Study, US Professional Association of Transgender Health, Los Angeles, CA, 2017

63. **Olson-Kennedy J**, Outside of the Binary; Care for Non-Binary Adolescents and Young Adults, US Professional Association of Transgender Health, Los Angeles, CA, 2017

64. **Olson-Kennedy J**, Olson-Kennedy A, Gender Dysphoria: Beyond the Diagnosis, Center for Juvenile Justice Reform Supporting the Well-Being of LGBTQ Youth Certificate Program, Washington DC, 2018

65. **Olson-Kennedy J**, Olson-Kennedy A, Gender Dysphoria; Beyond the Diagnosis; Midwest LGBTQ Health Symposium, Chicago, IL, 2018

66. **Olson-Kennedy J**, Puberty Suppression and Gender Affirming Hormones, Gender Fest, Las Vegas, NV, 2018

67. **Olson-Kennedy J**, Gender Dysphoria; Beyond the Diagnosis, Gender Odyssey Family Conference, Seattle WA, 2018

68. **Olson-Kennedy J**, Gender Affirming Hormone Therapy for Transmasculine Adolescents and Young Adults, Gender Infinity, Houston, TX, 2018

69. **Olson-Kennedy J**, Outside of the Binary; Care for Non-Binary Adolescents and Young Adults, Gender Infinity, Houston, TX, 2018

70. **Olson-Kennedy J**, Chest Dysphoria and the Impact of Chest Reconstruction, Gender Infinity, Houston, TX, 2018

71. **Olson-Kennedy J**, Olson-Kennedy A, Landon S, Just a Girl, Just a Boy, Gender Infinity, Houston, TX, 2018

72. **Olson-Kennedy J**, Hormones 201: More than Testosterone and Estrogen, Gender Odyssey Professional Symposium, WA, 2018

73. **Olson-Kennedy J**, Puberty Suppression: What, When, and How, Gender Odyssey Family Conference, Seattle WA, 2018

74. **Olson-Kennedy J**, Gender Google; Gender Odyssey Family Conference, Seattle WA, 2018

75. **Olson-Kennedy J**, Male Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults, Gender Odyssey Professional Symposium, WA, 2018

76. **Olson-Kennedy J**, Mosser S, Chest Surgery, Gender Spectrum, Moraga, CA 2018

77. **Olson-Kennedy J**, Olson-Kennedy A, Understanding Gender Dysphoria, Gender Spectrum, Moraga, CA 2018

78. **Olson-Kennedy J**, Puberty Suppression and Gender Affirming Hormones, Gender Odyssey, Los Angeles, CA, 2018

79. **Olson-Kennedy J**, Olson-Kennedy A, Gender Dysphoria – Beyond the Diagnosis, Gender Odyssey, Los Angeles, CA, 2018

80. **Olson-Kennedy J**, Olson-Kennedy A, Transyouth Care – Self-reflection on Personal Biases and Their Impact on Care, Society for Adolescent Health and Medicine, Seattle WA, 2018

81. **Olson-Kennedy J**, Rethinking Gender, Society for Adolescent Health and Medicine, Seattle WA, 2018

82. **Olson-Kennedy J**, Providing 360 degree transgender hormone therapy: beyond the protocols, Medical Directors Council (MeDC) 14th Annual Clinical Update in Reproductive Health and Medical Leadership, Snowbird, Utah, 2018

83. **Olson-Kennedy J**, Olson-Kennedy A, Gender Dysphoria: Beyond the Diagnosis, Gender Education and deMystification Symposium, Salt Lake City, Utah, 2018

84. **Olson-Kennedy J**, Rethinking Gender, SoCal LGBTQIA Health Conference, Los Angeles, CA, 2018

85. **Olson-Kennedy J**, Hormones 201 – Beyond T and E, Gender Odyssey San Diego, San Diego, CA, 2019

86. **Olson-Kennedy J**, Olson-Kennedy A, Landon S, Just a Boy, Just a Girl, Gender Odyssey San Diego, San Diego, CA, 2019

87. **Olson-Kennedy J**, Gender Dysphoria; A Deeper Dive Beyond the Diagnosis, Advance LA Conference, California

88. **Olson-Kennedy J**, Histrelin Implants for Suppression of Puberty in Youth with Gender Dysphoria: a Comparison of 50 mcg/day (Vantas) and 65 mcg/day (SupprelinLA), WPATH Conference, Virtual Presentation, 2020

89. **Olson-Kennedy J**, Chest Reconstruction and Chest Dysphoria in Transmasculine Adolescents and Young Adults, Comparison of Post-surgical and Non-surgical Cohorts, WPATH Conference, Virtual Presentation, 2020

90. **Olson-Kennedy J**, Olson-Kennedy A, Gender Dysphoria: Beyond the Diagnosis, Center for Juvenile Justice Reform Supporting the Well-Being of LGBTQ Youth Certificate Program, Virtual Presentation, 2020

MEDIA AND TELEVISION APPEARANCES:

2008, Lost Little Boy, The Dr. Phil Show
2011, My Extraordinary Family, ABC Nightline
2011, Transgender Youth, Rosie O'Donnell's The DOC Club
2011, Adolescents and Bullying, Dr. Drew show
January 2012, Transgender Child: A Parents' Difficult Choice, Our America with Lisa Ling, OWN Network

May 2012, Transgender Teen's Journey From Meghan to Mason "Really, Really Good" NBC, Bruce Hentsel Show

July 2012, Living a Transgender Childhood, Dateline

July 2013, Boy to Girl, One Child's Journey, People Magazine

October 2013, Coy Mathis: One Child's Fight to Change Gender, Rolling Stone Magazine

June 2014, Born This Way: Stories of Young Transgender Children, CBS The Sunday Morning Show

January 2015, Eisenhower Medical Center Hosts Transgender Symposium, Desert Sun

January 2015 Transgender 13-year-old Zoey having therapy, BBC

January 2015, The DeMita Fletcher Family: What We Learned From Our Transgender Son, People.com

January 2015, Driven to Suicide?, People Magazine
April 2015, Transgender Teen Opens Up about Struggles, Journey, ABC 7

April 2015, Transgender community, allies see Jenner interview in positive light, LA Times

April 2015, Bruce Jenner's transgender journey will lead to more understanding, many say, Daily News

April 2015, Fellow Olympian on Bruce Jenner's Transgender Announcement: 'Hardest Thing I Could Ever Imagine' ET Online

April 2015, Local Teens Hopes to Inspire Transgender Youth by Speaking Publicly About Transition, KCBS

May 2015, Boy, You'll Be a Woman Soon, Elle (France)

June 2015, Clinics Serve Transgender Kids, LA Times

July 2015, 'I Am Jazz': Transgender Teen on Grappling with High School, Puberty, ABC/Nightline

July 2015, Transgender experience isn't caused by a hormone imbalance so just give it up already
A new study confirms what researchers have long been saying: Gender dysphoria isn't physiological, Salon

July 2015, New study proves transgender status is not the result of a hormone imbalance, Examiner.com

July 2015, Transgender youth have typical hormone levels, Science Daily

July 2015, Health Effects of Transitioning in Teen Years Remain Unknown, NPR

July 2015, STUDY: Being Young and Trans Is Not the Result of a Hormonal Imbalance

July 2015, Transgender Kids Found to Have No Hormone Abnormalities Contributing To Their Experience, The Advocate

July 2015, No Difference in Hormone Levels of Transgender Youth, Science 2.0

July 2015, Transgender Youth Don't Have Hormone Abnormalities, Doctors Lounge

July 2015, Parenting My Transgender Teen: Britt Rubenstein, Mom-Momstampblog

August 2015, Identifying as a Different Gender, Student Science

August 2015, Inside Vanity Fair: Trans America, Our New Special Issue on Gender Identity and Expression, Vanity Fair

August 2015, Why There's a Medical Crisis for Transgender Youth, The Hollywood Reporter

August 2015, Transgender Medical Crises, Daily Kos

August 2015, Op-ed: Jazz Jennings is TV's Unsung Trans Heroine, Buzz Feed

October 2015, Pausing Puberty with Hormone Blockers May Help Transgender Kids, Fox News

November 2015, Al Jazeera America – Betrayed by their bodies: For trans teens, puberty can be a trauma

November 2015, Daycare workers fired for not acknowledging 6-year-old as transgender boy, Rolling Out.com

Jan/Feb 2016, Young and Transgender, How to Best Help Them Thrive, Scientific American Mind

EXHIBIT B

Bibliography

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Filing Description: PLAINTIFFS' VERIFIED ORIGINAL PETITION FOR DECLARATORY JUDGMENT AND APPLICATION FOR TEMPORARY AND PERMANENT INJUNCTIVE RELIEF
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