# Exhibit 8

CAUSE NO.

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| 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

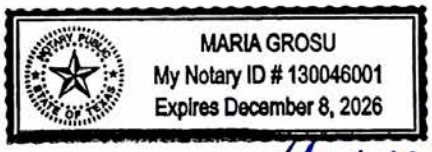
**JURAT**

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